IN THE CIRCUIT COURT FOR
SUMTER COUNTY, ALABAMA

JIMMY C. ACTON,)

Plaintiff(s),)

v.) CIVIL ACTION NO.: CV-96-98

R.J. REYNOLDS TOBACCO COMPANY, et al.,)

Defendant(s).

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THE DEPOSITION OF
WILLIAM M. PATTERSON, M.D.

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S T I P U L A T I O N S

IT IS STIPULATED AND AGREED, by and between the parties through their respective counsel, that the deposition of William M. Patterson, M.D., may be taken before SHERRY TUDOR, Court Reporter and Notary Public for the State of Alabama at Large, at the law offices of Maynard, Cooper & Gale, P.C., AmSouth/Harbert Plaza, 1901 6th Avenue North, Suite 2400, Birmingham, Alabama, on the 26th day of February, 1999.

IT IS FURTHER STIPULATED AND AGREED that the signature to and the reading of the deposition by the witness is not waived, the deposition to have the same force and effect as if full compliance had been had with all laws and rules of Court relating to the taking of depositions.

IT IS FURTHER STIPULATED AND AGREED that it shall not be necessary for any objections to be made by counsel to any questions, except as to form or leading questions, and that counsel for the parties may make objections and assign grounds at the time of the trial, or at the time said deposition is offered in evidence, or prior thereto.

IT IS FURTHER STIPULATED AND AGREED that the notice of filing of the deposition by the Commissioner is waived.

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A P P E A R A N C E S

On Behalf of the Plaintiff(s):

J. GREG ALLEN, ESQUIRE

BEASLEY, ALLEN, CROW, METHVIN, PORTIS & MILES, P.C.

218 Commerce Street

Post Office Box 4160

Montgomery, Alabama 36103-4160

On Behalf of the Defendant, Brown & Williamson:

W. RANDALL BASSETT, ESQUIRE

KING & SPALDING

191 Peachtree Street

Atlanta, Georgia 30303-1763

On Behalf of the Defendant, R.J. Reynolds:

RICHARD G. STUHAN, ESQUIRE

JONES, DAY, REAVIS & POGUE

North Point

901 Lakeside Avenue

Cleveland, Ohio 44114

A P P E A R A N C E S
continued

Also Present:

THOMAS A. DUNCAN, ESQUIRE

SHOOK, HARDY & BACON, LLP

One Kansas City Place

1200 Main Street

Kansas City, Missouri 64105-2118

Before:

Sherry Tudor, Court Reporter and Notary Public

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EXHIBITS

I, SHERRY TUDOR, a Court Reporter of Birmingham, Alabama, acting as Commissioner, certify that on this date, as provided by the Alabama Rules of Civil Procedure and the foregoing stipulations of counsel, there came before me at the law offices of Maynard, Cooper & Gale, P.C., AmSouth/Harbert Plaza, 1901 6th Avenue North, Suite 2400, Birmingham, Alabama, beginning at or around 9:30 a.m., WILLIAM M. PATTERSON, M.D., witness in the above cause, for oral examination, whereupon the following proceedings were had:

WILLIAM M. PATTERSON, M.D.,

having been first duly sworn, was examined and testified as follows:

THE COURT REPORTER: Usual stipulations?

MR. ALLEN: Yeah, the usual stipulations will be fine.

Doctor, do you want to read and sign the deposition?

MR. BASSETT: We do want to

reserve signature. I just want to make sure we understand the stipulations, being from Atlanta; that we're reserving all objections except for those to the form of the question, responsiveness of the answer, till such time as used at trial.

We've also had a stipulation that one objection by one of the counsel for defendants would apply to all defendants.

MR. ALLEN: That's fine with me. Since this is not my primary case -- I'm taking the deposition for Graham -- would y'all tell me who you are and who you represent on the record?

MR. BASSETT: Sure. I'm Randy Bassett, and I represent Brown & Williamson Tobacco Corporation.

MR. STUHAN: I am Rick Stuhan. I represent R.J. Reynolds Tobacco Company.

MR. DUNCAN: I'm Thomas Duncan and Brown & Williamson.

MR. ALLEN: What firms are y'all with? You're with King & Spalding?

MR. BASSETT: King & Spalding.

MR. ALLEN: And you're with --

MR. DUNCAN: Shook, Hardy & Bacon.

MR. ALLEN: Shook, Hardy & Bacon.

* * *

EXAMINATION BY MR. ALLEN:

Q Would you state your full name for the record, please, sir?

A William Morrow Patterson, M.D.

Q Dr. Patterson, my name is Greg Allen. I represent Mr. Acton in the case. And I'm going to be asking you questions here today.

Do you understand that I'm here to try to find out what your opinions are going to be at the trial of this case?

A Yes.

Q And do you plan on doing your best to try to convey to me your opinions so that I'll have some understanding of what you're going to say in court when I leave here today?

A Yes.

Q When were you first contacted about Mr. Acton's case?

A It was June of '98.

Q And who contacted you?

A It was Mr. Bassett from King & Spalding.

Q And what were you asked to do?

A I was asked to -- if I would be willing to look at some depositions in a case in Alabama. He identified it as the Acton case, that this case would be tried most likely in Alabama, and wanted to know if I would look at these depositions and consider agreeing to serve as a consultant in the case if requested to do so. And I agreed to do that.

Q Did Mr. Bassett tell you how he got your name?

A I believe he got my name from an attorney that I had worked with before at Shook, Hardy & Bacon.

Q And who is that attorney?

A Don Kemna.

Q I'm sorry?

A I think it was Don Kemna, K-E-M-N-A.

Q And what work had you done in the past at Shook, Hardy & Bacon?

A A similar type work. Reviewing depositions and medical records, et cetera, and rendering opinions based on those reviews.

Q How many times have you rendered opinions similar to what we're here about today?

MR. BASSETT: Let me object to the form of the question.

A I don't know exactly, but it's been probably six times or so. Certainly less than ten.

Q (BY MR. ALLEN) Can you give me or did you bring with you a list of litigation as we requested in the notice of deposition?

A Well, I don't have a list of -- a list of --

Q Cases where you've testified.

A Oh, I've not testified in any cases.

Q Well, by deposition. Is this the first --

A I have not given any depositions.

Q Have you -- well, have you given depositions as a consultant in any litigation prior to today?

A Yes.

Q Did you bring that list with you?

A No.

Q Do you have such a list?

A I believe I do. I believe I do.

(Plaintiff's Exhibit A was marked for identification.)

Q Well, let me show you the notice of deposition I've marked as Plaintiff's Exhibit A.

A Okay.

Q Have you seen that notice of deposition?

A No.

Q Did the lawyers retaining you tell

you that I had asked at this deposition that certain documents be produced, including a list of cases you've been involved in?

A I don't recall that, no.

Q Have you met with the attorneys for the tobacco companies some prior to today?

A Yes.

Q And did you discuss your testimony? Did you discuss what your opinions would be?

A Yes, I discussed what my opinions would be.

Q And who did you meet with?

A The first time, which I believe was around July or so of '98, I met with about three attorneys, and after reviewing the depositions and discussed my opinions based on my review of the depositions in the Acton case.

And then I think it was around October or November or maybe August we had another meeting with two attorneys.

And then yesterday, the 24th, I met with three attorneys to discuss my opinions in the case.

MR. BASSETT: I don't mean to interrupt you. Are we going to mark those Exhibit A?

MR. ALLEN: This is marked.

MR. BASSETT: Okay.

Q (BY MR. ALLEN) How long did you spend with them yesterday?

A Three and a half hours.

Q And during that three and a half hour period no one mentioned to you that you were asked to bring information to this deposition?

A No.

MR. ALLEN: Are y'all going to produce the documents we requested at the deposition?

MR. BASSETT: Well, I don't know if I've actually seen the notice. What we did produce is we had him bring with him all the materials that he relied on in forming

his opinions in the case. I think there's some additional records back at the office that he could talk about that I don't believe he specifically relied on but that he also received.

MR. ALLEN: Well, the question I had is are y'all going to produce the documents that I requested in the notice of deposition?

MR. BASSETT: Well, what's in the notice that hasn't been --

MR. ALLEN: Are you telling me you haven't seen the notice of deposition?

MR. BASSETT: I don't know that I've looked at it to -- well, I would suggest you could question Dr. Patterson about it and see what he's got with him, and we can decide what he does not have.

Q (BY MR. ALLEN) At your office do you have a list of cases that you've testified in in the past?

A I believe I do.

Q And is there somebody at your

office that can make a copy of that?

A Yes.

Q Would you mind calling them and have them copy it so I can pick it up on the way out of town?

A Yes, that will be fine. My office closes at noon, but maybe we can work something out.

Q At the first break how about calling your office and telling them to make a copy of that list so I can pick it up. I'm heading back to the office anyway.

MR. BASSETT: Or we can -- I mean, if we can't get it today, I assume we can send it over to you.

MR. ALLEN: Well, I just thought he said he could get it today.

So I'll just pick it up on the way back. Thank you.

MR. STUHAN: Well, wait a minute. I'm not for a moment going to concede that you're entitled to any such list. We're not in federal court.

I might add that we've asked for the very same information from plaintiff's witnesses and have not gotten that information. So if we're going to be turning over a list of prior testimony, I certainly expect to obtain reciprocity from the plaintiff with respect to plaintiff's expert witnesses in the case.

As far as the notice of deposition is concerned, you unfortunately haven't been present in other depositions. But Graham Esdale and I have had exchanges about that. It has been our position consistently that those notices of deposition are overly broad and call for information that goes well beyond the kind of expert discovery to which you're entitled under the Alabama Rules of Civil Procedure. And we've said that time and time again. So we object to that notice.

Beyond that, I also think that that notice is of no legal effect whatsoever; was not attached to a subpoena. Dr. Patterson

is not a party. Simply attaching a request for production to a notice to someone in his position just has no legal effect as far as we're concerned.

MR. ALLEN: Are you finished?

MR. STUHAN: Yes.

MR. ALLEN: I'm going to pick the list up as I go out today.

Q (BY MR. ALLEN) Have you had a chance to look at this notice of deposition at all?

A Well, I glanced over it.

Q How about looking over it, and just as to each number tell me which documents you have with you today. And if there are documents that you have that you don't have with you today that fall within the scope of that notice, tell me where they are. You can call it out as to No. 1, then as to No. 2. That will be fine.

A Number 1 is testimony and documents evidencing or relating to any and all documents, correspondence, reports,

medical reports, photographs, standards, charts, memos or writings of any kind reviewed by said expert in preparing for this case.

I didn't review any testimony unless you consider depositions testimony.

Q It certainly is.

A Okay. I reviewed the depositions of Buren Smith Acton and Jimmy C. Acton, and those are with me. And then I also -- I reviewed the medical reports of Buren Acton.

Q Do you not have those with you?

A And I have those with me.

Q All right.

A I scanned -- I received approximately two boxes of medical records on Jimmy Acton which were very extensive and mostly had to deal with -- there was no psychiatric records in there that I was aware of. And I just scanned over those. Those are located at my home at [DELETED]

And I also received -- I don't

have any photographs, charts, memos or writings except, for example, the -- the letter from Mr. Bassett thanking me for agreeing to consult in the matter, and in closing stating that he was enclosing the depositions for me to review.

And then lastly, I received some articles related to smoking addiction and so forth in a Fed Ex box over the past two weeks or so. And those are located in my home as well.

And then lastly, I received the depositions of a Dr. Thrasher and a Dr. Feingold. I scanned over those two depositions and decided that they were mostly medical -- related to the medical aspects of Mr. Acton. And, therefore, I don't have those with me today. I made no marks on them, no highlighting or anything.

Number 2 is testimony and documents evidencing or related to any and all documents, correspondence, reports, charts, memos, photographs, drawings,

blueprints, so forth. Most of that wouldn't apply except as I've already discussed.

Number 3 --

Q I'm sorry, you do not have any of those? Is that your testimony?

MR. BASSETT: I'm going to object to the characterization of testimony.

A Yeah. The only thing is I do have a disclosure statement with me. And I guess that might be considered a report, because these are very general, broad -- general terms.

Q (BY MR. ALLEN) That's fine.

A And I'm not sure exactly what exactly --

Q I just want to be sure we're talking about the same thing.

A -- you're asking. And it says testimony and documents related to any and all opinions of said expert -- memoranda, documents, notes and writings of any kind.

I don't have any personal notes. I didn't take any personal notes. But I do

have this disclosure statement that I read, approved, and brought with me.

Q But you did not prepare any reports? Is that your testimony?

A No. No.

Q Okay.

A Testimony and documents evidencing or relating to said expert's education, background, experience, qualifications.

I have a CV that's present with Randy -- that Randy Bassett has that he brought here. I didn't bring another CV since he was bringing that one.

Q That's fine.

A Lawsuits and claims which the expert has consulted or testified. We've discussed that.

Each and every item of correspondence, memo, or any other document in this expert's file.

That -- the correspondence is very sparse, and it's like this initial letter from Mr. Bassett. Otherwise, it would

just -- there would be maybe cover letters with depositions that just said I have enclosed the depositions for you to review.

Q Where are those letters?

A They're with -- they're like with Thrasher and with Feingold. They're with those depositions. It's just simply cover letters.

Q Okay.

A Number 6 -- I mean No. 7, each and every memo, item of correspondence, document or any other items sent from any of the attorneys for the defendant to the expert. Sent from any of the attorneys. I'm not sure I understand that one.

Q Let me see it. Let me read it again.

A Number 7.

Q Yeah, that's anything they've sent to you in connection with this case.

A Well, I've -- I've already discussed all of them so far.

Q Was that everything that you --

you mentioned to me the Federal Express package?

A Yes. That was containing the articles, many of which I already had or have read.

Q And where did you say the Federal Express package was?

A It's at my home.

Q And would you have any objection to producing that for me?

MR. BASSETT: Well, let me just state that again, as Mr. Stuhan stated earlier, I think there's been some question about reciprocating and obtaining documents that the experts may have or have not -- and, specifically, Dr. Feingold.

There is substantial discussion and disagreement over what documents Dr. Feingold was going to provide. And if we're going to turn over this material, I would request reciprocity from plaintiff's.

MR. ALLEN: Well, the issue, I think, is whether it's discoverable. And

certainly it's discoverable if y'all sent it to him. So, you know, we'll make a formal request and you make a formal objection.

MR. BASSETT: That's fine.

Q (BY MR. ALLEN) Describe the Federal Express package and the articles that the tobacco company sent you.

A It looked to be like maybe sixty -- fifty, sixty articles on everything from caffeine to smoking to -- there was a -- an excerpt from the '64 Surgeon General's report.

And it was just articles related to addiction, dependence. Some of them are animal -- articles on animal studies and so forth.

Q And you said some of those you already had?

A Yes, some of them I had reviewed before and had read on my own even.

Q Did you bring any of those articles with you, the ones that you already had?

MR. BASSETT: Let me object to the form of the question. It's compound.

A The only article I brought with me was an excerpt from the 1964 Surgeon General's report to refresh my memory.

Q (BY MR. ALLEN) Sure. Is that one of the articles that was included in the Federal Express package that was sent to you by the tobacco lawyers?

A This is the article.

Q The one that came from them?

A Yes.

Q Any others that you pulled out of the Federal Express package that you brought with you?

A No.

Q Now, I think the gist of the request was we wanted basically anything that you have gotten from them in connection with your consulting. And I'm not limiting it to just this case, since you've consulted in other tobacco cases.

Have you received anything else at

any time from either tobacco companies directly or the attorneys representing the tobacco companies?

MR. BASSETT: Let me object to the form of that question. To the extent Dr. Patterson understands, he can answer it.

A I've received other documents similar to this. When I would agree to consult on other cases, they would send depositions and so forth. And some are at my home, some are at my office and so forth.

Q (BY MR. ALLEN) Have any of those packages -- or whatever that you received would include articles similar to the articles that you discussed earlier?

A Yes.

Q Do you have all those collected somewhere?

A No.

Q They aren't at your home?

A That's what -- as I said a while ago, they're in different places. They're at my home, they're at my office, depending

on, what I would call, the status of the case.

Q Which of the cases -- of the six cases, I think you mentioned, would be involved in litigation currently?

A None that I know of.

Q And when I say litigation, where the suit is filed, if you know.

A I don't know.

Q But as I understand it, you've not offered an opinion in any of those other six cases?

MR. BASSETT: Let me object to the form of the question.

A Not in a deposition.

Q (BY MR. ALLEN) Not in a similar format that you showed me earlier, where it's what we call a Rule 26 Disclosure, summary of your expected testimony?

A I believe I have done some disclosure before, yes.

Q And can you tell me the names of those cases?

MR. STUHAN: I'd object to that question on the ground that it calls for work product protected information, and I'll instruct the witness not to answer.

MR. ALLEN: Are y'all saying he's not been disclosed as an expert in any of those cases?

MR. STUHAN: That's correct.

Q. (BY MR. ALLEN) In the other six cases, can you tell me what law firms you were working for?

A. Well, I have -- I do some forensic work in my practice, and the law firms get very blurry. But to the best of my recollection, the only two law firms I can remember are you requested from the attorneys present today, which is Shook, Hardy & Bacon and King & Spalding. That's the only two I recall.

MR. STUHAN: Greg, before you pose your next question, co-counsel tells me that Dr. Patterson actually has been disclosed in the Costano case. So let me

correct the record to reflect that fact.

THE DEPONENT: That document --

MR. ALLEN: That's the only one?

MR. BASSETT: Well, we believe it's the only one. I mean, we can take a quick break and discuss it.

MR. DUNCAN: He may have been -- yeah, we can discuss it. He may have been disclosed in others.

THE DEPONENT: And that particular document was called an affidavit.

MR. ALLEN: Yeah. And I was going to ask you about that.

THE DEPONENT: If that makes a difference. I don't know.

Q (BY MR. ALLEN) Well, do you have a copy of the affidavit either at your home or your office?

A I most likely do.

Q Do you think that was in --

A I don't know for sure, but I believe I do.

Q You think that was in the Costano

litigation?

A I believe it was.

Q Have you given any other affidavits in any other tobacco litigation?

A Not that I recall.

Q Have you ever done work for any of the Birmingham firms that are involved in this -- in the Acton litigation? And that would be -- I know Sam Franklin's firm is involved, and Tommy Wells' firm is involved.

A Say it again, now.

Q Have you ever done work, consulting-type work, for either the Lightfoot, Franklin law firm or the -- what's the name of this firm?

MR. BASSETT: Maynard, Cooper.

Q (BY MR. ALLEN) -- Maynard, Cooper firm?

A Yeah. As I explained a while ago, these firms get a little blurry to me. Lightfoot and Franklin, it seems like I recall doing like a -- what I would call an IME, independent medical evaluation, on at

least one patient or more for them for, say, a workers' comp case or whatever. I'm just guessing.

Q Could have been more?

A Because I don't do a lot of it. But I have done some. And that firm does ring a bell, but I can't be certain.

Q Does the Maynard, Cooper firm ring a bell?

A It doesn't ring a bell with me; although, I have heard of the firm's name in Birmingham.

Q Well, have you done any other independent work for any of the other law firms involved, either King & Spalding or whatever, that's not tobacco litigation?

A Yes, I've done work for other -- other firms. And this would usually involve psychiatric cases. Sometimes my own patients.

Q Would that include work with the King & Spalding law firm out of Atlanta?

A No.

Q How many times would you say in your practice you have given deposition testimony?

A I would estimate maybe ten or fifteen times since I've been in practice in Hoover, which was I think '93 or '95 -- '93. I'm sorry.

Q Well, I wasn't limiting it to when you were in practice at Hoover. I'm limiting it to your career.

A Well, I was at the University for eight years. And I don't remember giving any depositions there because I did very little forensic work there except for the State Department of Mental Health.

Q So, basically, ten or fifteen times total; is that correct?

A Yes.

Q Now, No. 8 in the request for production connected with the notice of deposition labeled as Plaintiff's Exhibit A indicates that we had asked for a complete list of each and every lawsuit or case that

the expert has done any consulting work in. And we've talked about that. That list is at your office; is that correct?

A Yes.

Q Number 9 asks for any documents, which would include any contracts or writings, confirming your employment in this case.

Is there anything in writing relative to your consulting work in this case?

MR. BASSETT: Object to the form of the question.

A No, there's no formal or contracts. Only what I have mentioned previously, like this letter from Mr. Bassett just thanking me for agreeing to consult in the case.

Q (BY MR. ALLEN) Is there any written contract between you and a tobacco company or a lawyer representing a tobacco company in any tobacco litigation?

A No.

Q Item No. 10 asks for information I think I may have already covered. But that would be any writings, basically, notes about the opinions you're going to offer in this case. Have you told me about all those?

A Yes. Except for I did make some notes. I didn't make any formal notes, but notes on the very front page of a deposition. And then I would highlight things that I thought were important. But these are simply things like dates of things, like diagnosed with CA April '95. That's the kind of notes. It's just things that's contained in there.

Q That's fine.

A Just to jog my memory.

Q In other words, any notes you have are here?

A Yes.

Q Did you bring with you, as requested in No. 11, any documents that would have evidenced the hours that you have

in this case or your billing records?

A No.

Q Have you rendered a bill for any of the services you provided in this case?

A No.

Q Do you plan on doing that?

A Yes.

Q What is the hourly rate that you intend to charge for your involvement in this case?

A I charge a hundred and thirty-five dollars an hour for reviewing records, and I charge two hundred dollars an hour for consultations, for depositions, giving testimony at a trial.

Q So it's two hundred for your testimony and trial work; is that correct?

A Yes.

Q Are there any other charges other than what you just told me? Or is there any retainer, for example?

A No.

Q Have you been paid for any of the

work you've done in this case?

A No.

Q How many hours have you put into the work that you've done in the Acton case?

A I've put over twenty hours in the Acton case. About -- I believe it's about twenty-nine hours.

Q And what all would that consist of?

A It would consist of reviewing the depositions, phone consultations, actual meetings in my office or what I call office consultations with the attorneys on the three occasions that I've already mentioned. And it would list reviewing articles. And then like today, I will list this deposition and the time that I spent here.

Q Now, in the other six cases where you have worked in tobacco-related litigation, have you sent any bills for your time and work in those cases?

A Yes.

Q Can you give me an idea of how

much you've made in working with the tobacco companies?

A I don't know for sure, but I would estimate it would be less than ten thousand dollars total.

Q How long have you been working with the tobacco companies?

MR. BASSETT: Object to the form.

A I don't know for sure. But as I recall, the Costano case, whenever that case was brought up -- as I recall, that was a class action suit -- was the first case that I was asked to consult on, whenever that was.

Q (BY MR. ALLEN) You don't -- can you give me an estimate?

A Well, I would estimate '94, '95, maybe.

Q And do you remember who originally contacted you on behalf of the tobacco companies to get involved in consultation with them?

A I can't be for certain, but I

believe it was Don Kemna with Shook, Hardy & Bacon.

Q The notice of deposition item 12 asks basically for any deposition summaries that you've been provided.

Have you either summarized depositions -- and I'm not talking about the notes you made on -- do you have a separate summary of the depositions, or have you been provided with a summary of depositions?

A No.

Q Item 13 asks for articles that you have written. Would your CV list all of the articles you've written?

A Yes.

Q Do any of those articles deal with tobacco?

A No.

Q Do any of the articles on your CV or any articles you've written deal with addiction?

MR. BASSETT: We object to the form of the question, the term "deal with."

A Not as a primary subject or not in the title itself. It might be contained in the -- in the body of the paper itself, matters relating to drug abuse or dependence or whatever. But not in the title itself.

Q (BY MR. ALLEN) Would it be fair to say that none of the articles you've written had as their central theme addiction?

MR. BASSETT: Object to the form of the question.

A I don't recall writing an article on addiction itself as a central theme.

Q (BY MR. ALLEN) What specialized studies have you been involved in to study addiction?

A I'm not sure I understand what you're asking.

Q Any research projects, specialized studies?

A In addiction --

Q Yes, sir.

A -- of -- just addiction in general

or --

Q Yes, sir. Or in particular. I'll say tobacco, as well. But just generally what -- I want to know what your knowledge base is and your study and research in the area of addiction, which I understand you're going to testify about in this case.

MR. BASSETT: Let me object to the form of the question. I think it's become compound and more vague. But to the extent Dr. Patterson can answer, he may.

A I haven't done any research into addiction in and of itself. I have done extensive research in psychiatric and psychoactive drugs over the past seventeen years. A lot of the psychiatric drugs on the market today I have studied.

I did a study with a narcotic analgesic called Ultram with pain. I was a consultant to the Pain Center at UAB for eight years. And almost all of these patients' addiction, drug abuse, drug dependence, narcotic use, et cetera, was

always an issue that I was asked to deal with as a psychiatrist.

In my practice a lot of my patients who may have depression or anxiety or other problems may also have problems with alcohol, elicit drugs, et cetera. Some of my patients do smoke. I don't know the number.

And then in my training, of course, as a psychiatrist and at CME courses I've attended, I was trained in drug and alcohol abuse that was required. I was asked questions about it to be certified as a psychiatrist in 1976.

When I was a resident at Letterman Army Medical Center from 1972 to '75, I ran a detox unit for Vietnam returnees who were, quote, addicted to drugs and alcohol returning from Vietnam. And I did that for approximately a three-month period of time.

So drug and alcohol abuse, the assessment of patients who may have drug and alcohol abuse, it's effects, it's

psychiatric effects, the possibility of co-morbid disorders with drug and alcohol abuse, I've dealt with this extensively since I graduated as a resident in 1975. So that's about twenty-four years with my whole patient population.

Q (BY MR. ALLEN) Don't some people engaged in your field specialize in handling addictions?

A Some physicians are designated or call themselves addictionologists. In my experience and to my knowledge, most of these physicians are not psychiatrists, and it tends to be predominantly internists or family practitioners.

Q I'm sorry, I didn't mean to interrupt you. But I'm talking in terms of people in the psychological or psychiatric field. Are there specialists in the area of -- who specialize in the area of treating people with addictive behavior?

MR. BASSETT: Let me object to the form of the question.

A Well, I know there are some physicians and maybe there are some psychiatrists who limit their practice to drug and alcohol abuse. And I don't limit my practice to drug and alcohol abuse, but the patients as a whole, whatever problem they might be presented with. And this might include drug and alcohol abuse, but not just in that one narrow area.

Q (BY MR. ALLEN) What percentage of your patients -- you mentioned the co-morbid alcohol abuse. But I'm talking about as far as where the purpose of treating the person who's coming to you is to help them get off either drugs or alcohol. What percentage of your practice would that include?

A Well, you're talking about drugs or alcohol; right?

Q Yes, sir.

A Okay. I would say maybe twenty-five percent of the patients who come to me talk about or whatever, or their family may talk about a problem with drugs

or alcohol. Usually it's alcohol. And I will address that issue if it comes up in their history. If it comes up in their medical records or is brought to my attention, I'll address that issue just like I do symptoms of depression or anxiety or whatever, and do what I can to help them in that area.

Q Are you saying twenty-five percent of your practice, though, are patients who come to you because of alcohol or drug abuse?

MR. BASSETT: Object to the form of the question.

A Generally, patients don't come to me specifically for, say, treatment of drug or alcohol abuse. They'll usually go to a drug or alcohol abuse treatment center if they're going to go.

Q (BY MR. ALLEN) Well, I just want to see is there -- do you treat patients -- is there any percentage of your practice where the patient that's coming to you is

for the purpose of you dealing with their drug or alcohol abuse as the primary problem?

A No. As I said a while ago, most of the time that I can recall, patients come to me presenting multiple symptoms, or they might present with depression or anxiety. And then in evaluating them, taking a history, talking with their family, the drug and alcohol abuse comes out.

Q I'm not talking about that as a secondary issue. The question I have is: What percentage of your patients do you treat that come to you where the primary problem that they're coming to you for is either drug or alcohol abuse?

MR. BASSETT: Object to the form. Asked and answered.

A Well, I thought I had already stated that. But I'll restate it. I don't know of --

Q (BY MR. ALLEN) Is it zero percent?

A I don't know of any patients who have come to me specifically just for, Dr. Patterson, I want to be treated for alcohol abuse.

Q So the answer would be a zero percent?

MR. BASSETT: Object to the form.

Q (BY MR. ALLEN) Would that be correct? None?

A To the best of my knowledge

MR. BASSETT: Same objection.

Q (BY MR. ALLEN) Now, do you have affiliation or make rounds, I'll say, at any drug or alcohol abuse center?

A No.

Q Have you ever?

A Well, yes. I mentioned at Letterman, for example. I had to make rounds every day except on the weekend. Rounds would be usually made by the resident on call. And --

Q And what year are we talking about?

A That was from between '72 and '75. I would say around '73.

Q As I understood it, you said that the -- when you were involved with the detox center was for a period of three months?

A Yes.

Q Is that the time when you made your rounds?

A Yes.

Q Have you ever treated patients in your practice where the goal and the reason they came to you was to stop smoking?

A No.

Q And I need to ask the same question about your affiliations or making rounds with any center or group where the purpose is to assist the patients in stopping smoking.

MR. BASSETT: Object to the form.

A I have not done that.

Q (BY MR. ALLEN) Have you ever done any studies of smokers to determine the reason why they smoke?

A Have I done any actual research?

Q Yeah, where you've saw the patient, talked to them, tried to make -- you know, I say patient. I'm talking about group of patients or people, what I have in mind anyway, where you are actually studying a group of smokers for the purpose of making the determination of why they smoke.

A Not in and of itself. Only as it might relate if they present that to me in my clinical practice as a -- what they perceive as a problem.

Q But as far as actually studying groups of smokers to determine whether they either are addicted or what causes them to smoke, have you ever done that?

MR. BASSETT: Object to the form of the question.

A I've never had a patient to come to me and say I'm addicted to smoking and wanted help for that.

Q (BY MR. ALLEN) That's not the question. My question is: Have you ever

done any research projects where you are studying a group of smokers to try to determine why they smoke or how they can quit?

MR. BASSETT: Object to the form.

A No. As I stated a while ago, I have not done a discrete research project of any kind regarding smoking or smoking behavior.

Q (BY MR. ALLEN) What percentage of your patients -- well, first of all, how many patients do you see in a day?

A Including my research patients, I will see about six or eight a day.

Q When you talk about research patients, what specifically are you involved in?

A This is in the clinical drug trials that I was referring to earlier, psychiatric drugs.

Q I noticed in your CV you've been involved in and done some work for a number of drug companies over the years. And is

that primarily doing clinical trials for new drugs?

A Yes.

Q Did you ever do any of the research for either Zyban or NicoDerm or any other drug that has as its purpose the treatment of nicotine addiction?

MR. BASSETT: Object to the form.

A No.

Q (BY MR. ALLEN) Have you done any or do you plan to do any research on behalf of the tobacco companies relative to smoking, other than the litigation -- in the litigation area?

A No.

Q Have you ever received any moneys for any grants for research, either directly or indirectly, from the tobacco companies?

A No.

Q Tell me a little bit about the -- if you can. If it's not proprietary -- the research that you're doing today.

MR. BASSETT: Let me interpose an

objection. I think you noted if there's anything confidential that you can't discuss, we don't want you to divulge any of that.

A Well, I'm not supposed to discuss the specific drugs. But I am conducting clinical trials now, even today; and patients are being seen today by my what you call coordinators for psychiatric drugs in the area of depression, anxiety, panic disorder, and post-traumatic stress disorder, just that I can recall off the top of my head.

Q (BY MR. ALLEN) And of the patients that you see today in your practice, how many of those would be involved in your research or clinical trials?

A It would probably be about half of them.

Q And what would the other half consist of?

A That would be my private practice

patients.

Q Do you practice with anyone in your group, or are you a sole practitioner?

A No, I'm solo.

Q And how long have you been solo?

A I have been solo since -- I think it was 1990 or '91.

Q Is that when you left UAB?

A I left UAB in 1988, went with a group for about a year and a half or two, and then I went solo.

Q What was the group you were with for a year and a half?

A Birmingham Psychiatry, P.A.

Q That's still around as a group?

A Yes.

Q Who is the principal or the principals, I guess?

A Dr. Ed Logue, L-O-G-U-E.

Q Go ahead, since we're on this topic, and give me a summary -- I know you originally are from Gadsden; correct?

A Yes.

Q And I'm not asking about your educational background. But since you completed your education -- and I know you just told me a little bit about your residency in the Army; is that right?

A Yes.

Q Have you told me pretty much all that you can tell me about your residency as far as what you did?

MR. BASSETT: Object to the form.

A It's a very -- you know, it was a two-year program at the time, not counting an internship. And it -- I'm sorry, three-year program. Three-year program.

Q (BY MR. ALLEN) Sure.

A And it involved all aspects of psychiatry and psychiatric disorders. And it's sort of hard to describe what your residency consisted of, but it was everything from inpatient treatment of patients to consultations to outpatient treatment to psychotherapy, psycho-pharmacology, drug and alcohol abuse. And

just involved many topics.

Q Did you ever receive a specialty, I guess, in the area of psychology -- of psychiatry? Excuse me.

A No. I'm board certified in adult general psychiatry.

Q So when did you complete the residency training?

A In 1975.

Q And from that point would you just sort of give me a summary of your work history?

A In 1975, May or June, I was still in the military, and I was assigned to Eisenhower Army Medical Center at Fort Gordon, Georgia to -- to help start the third psychiatry residency training program in the Army.

At that time they felt they needed more psychiatrists, and they felt that training them in the military setting would yield more of a bigger number for them. Vietnam was still going on at that time, and

they felt they needed more psychiatrists.

So from 1975 to 1980 I was chief of the consult service, I was chief of the outpatient clinic and -- at Eisenhower Army Medical Center. And I did that for five years. And we did start the training program. And, of course, I was a teacher and supervisor, et cetera.

After -- in June of 1980 I took an appointment with the University of Alabama School of Medicine at Birmingham in the Department of Psychiatry as an assistant professor. And then at the University of Alabama, UAB, I was the director of training, head of the outpatient service, after serving a brief period with a consult service there consulting, in other words, to the medical/surgical units at UAB.

And then I worked up through the ranks to full professor and became vice chairman and director of training. I was still head of the outpatient clinic. I consulted to the Jefferson County Jail in a

forensic way through after training and certification by the Alabama Department of Mental Health and Mental Retardation. I was consultant to the Pain Center for eight years, the whole time that I was there.

And I supervised residents. I had my own practice, my own clinical practice. And I did research. I did research on drugs.

The first study that I ever did was with a controlled substance called Xanax, which has been on the market for years now, so I can mention that name. And then I've been doing clinical trials since that time.

I then left in 1988, went with this -- with Birmingham Psychiatry for about a year and a half; did not like the group setting for a practice and decided to go solo. And I've been solo ever since.

I spent about two years or so over at Hill Crest Hospital, which is a private psychiatric hospital in Birmingham. And I

had an inpatient and an outpatient practice and continued to do my clinical drug trials.

And then with change of administrators and discontentment with many of the psychiatrists on the staff, including me, I decided to open my own private practice in Hoover, Alabama, which is where I'm located today at 2120 Lynngate Drive in Hoover, Alabama.

And then I've been doing outpatient practice and research, clinical trials, since that time.

Q Do you have active staff privileges at any hospitals today?

A I had courtesy -- I had active non-admit privileges at Brookwood Hospital. And I dropped those privileges -- that status after I stopped my inpatient practice. And I have courtesy status at, I believe, Hill Crest and Medical Center East.

Q Now, just so I'll be clear -- and I think I understood -- you're board

certified in general psychiatry; is that correct?

A Yes, in October of '76.

Q Do you have any other certifications in any subspecialty in the field of psychiatry?

A No.

Q Are you a member of the American Medical Association?

A Yes.

Q And how long have you been a member of that organization?

A I don't know for sure, but I know it's been at least since the '80s. Probably the low to mid '80s.

Q I'm sorry.

A I'm sorry. In the military a lot of us did not belong to the AMA or the local medical societies, which you usually have to do both. But when I got out of the military, I joined the AMA and the local -- the county medical society and state.

Q So you've been a member since the

'80s; is that correct?

A Yes, the low '80s.

Q Are you a member of the American Psychiatric Association?

A Yes.

Q And how long have you been a member of that group?

A I was a member in training, which would be around '72, '73. And then after I graduated, I became a general member. So I've been a general member since about '75 or '76. And I'm also a fellow in the APA.

Q Since when? Approximately. I'm not holding you to any specific number.

A Yeah. I was at the University at the time, so it would be prior to '88.

MR. BASSETT: Is this a good time for a break?

MR. ALLEN: Sure.

(Whereupon, a break was taken.)

Q (BY MR. ALLEN) Dr. Patterson, let me ask you a few more questions. Have you ever been the subject of a malpractice

lawsuit? Have you ever been sued?

A I have a malpractice suit pending now.

Q Who is the attorney that brought that lawsuit?

A I don't know.

Q And I don't want to go into too much detail, but have you given a deposition in that case?

A No.

Q Who is the patient that brought the suit? I assume the patient brought the suit?

A I don't remember her name. This was a patient that I wasn't even treating.

Q What are the allegations, then, I guess?

A Malpractice, sexual harassment. I believe that's it.

Q And where is the case pending? What county?

A I guess it would be Jefferson County.

Q Who are the other physicians, if there are any, involved?
A None.
Q Is there a hospital named or --
A No.
Q You're the only defendant?
A Yes.
Q And you don't remember the name of the lady or gentleman that filed the suit?
A I believe -- I believe her name was Turner.
Q How long has it been pending?
A They filed it the day before statute of limitations ran out, and it was -- this is '99, so it was the end of '98, the fall to winter of 1998.
Q Do you have any of the pleadings at your office that you could look at to give me the name of the attorney who has filed the action?
A Yes, I probably do. I did make a file on it.
Q Did you call your office to get --

during the break to get --

A I called my office. My office manager is off today who has that list. The receptionist doesn't know where it is. And you couldn't physically get over and get it anyway by noon, unless you leave here and then come back and delay the deposition.

Q Well, could y'all have that ready by Monday?

MR. BASSETT: Let me interpose an objection. I mean, I think we've covered this ground before, as far as prior proceedings in trying to get that information. And I can't speak for Rick, per se. I'm happy to turn it over if we can have an agreement right now that y'all will do the same with each and every one of your --

MR. ALLEN: Look, you know this is Graham's case. I don't know what's gone on between y'all. And that don't have a dern thing to do with whether it's discoverable or not, and you know that. And there's no

doubt it's discoverable. And so if y'all are going to refuse to present it or produce it, then just say so.

MR. BASSETT: I don't think we're refusing.

MR. ALLEN: It sounds like it to me.

MR. BASSETT: But there's nothing compelling anybody to do that.

MR. ALLEN: Well, there will be if you're telling me you're not going to produce it.

MR. STUHAN: Well, it's not our decision to make. I think there's a great deal of question about whether it's discoverable. We have not instructed Dr. Patterson not to make that list available to you. As far as I'm concerned, that is a determination for him and him alone to make.

I will, however, state on the record to him that I do not believe that he has any legal obligation to turn that list over to

you.

Q (BY MR. ALLEN) Well, I guess the question is up to you, then, since the lawyers --

A If I don't have a legal obligation to turn it over -- I feel it's totally irrelevant to the question at hand today and that these -- as I recall the list, these were like workers' comp cases for pain and loss and post-traumatic stress disorder and so forth, and they have no bearing whatsoever.

So unless I'm compelled to do so legally, I'd rather not take the trouble of doing it.

Q And I assume -- I'm going to ask you the same question, and this is totally different. Do you have any objection to producing the papers that show the case that is filed against you that we just discussed?

A Which case?

Q The lawsuit that you were talking about, the malpractice suit.

A Well, I would want to consult with my attorneys on that. I'm not sure I should do that.

Q And who are your attorneys?

A They're with Mutual Assurance. That's my carrier.

Q Who's the lawyer?

A It's Starnes and his group. And don't ask --

Q Stan Starnes?

A Yes.

Q Now, have there been any other legal cases brought against you, Dr. Patterson?

A No.

Q Have you ever participated as an expert witness in any psychiatric malpractice cases either for a plaintiff or a defendant, where you gave a deposition and talked about the standard of care?

A No.

Q Have there ever been any allegations or claims made against you in

your practice to any of the medical boards or psychiatric boards, whatever they may be called?

A Medical boards?

Q Yes, sir.

A No, not that I recall.

Q That's fine. During the time that you were with UAB, were there ever any complaints made by any of your patients about your care or treatment of them to UAB?

A No.

Q Have you ever smoked cigarettes?

A Yes.

Q And tell me when did you first start smoking cigarettes.

A The first time I ever recall smoking a cigarette was probably around 15, 16 years old.

Q And why did you decide to smoke?

A I really don't recall. As I -- my recollection would be it was just to try it and see what it was like.

Q And did you continue to smoke?

A I have continued to smoke over the years. And I'm what some people refer to as a chipper in that I smoke two or three cigarettes a day.

Q And would that be true even up until today?

A Yes.

Q When do you smoke?

A At night before I go to bed.

Q And you smoke those two or three in the evening time?

A Yes.

Q Do you drink alcohol when you smoke those cigarettes?

A Not usually, no.

Q Sometimes?

MR. BASSETT: Object to the form.

A Well, I don't -- I don't drink at night. You know, I'm not -- I'm not inclined to sit and drink a beer or whatever in front of a TV. I have beer in my refrigerator that's probably ruined.

Q (BY MR. ALLEN) You sound like

me. So you don't drink alcohol regularly at all?

A No. Only I will have a glass of red wine. Usually I try to get in at least one glass a day based on the data that it may be useful cardiac-wise.

Q And how long have you done that?

A Since that data came out. I'm not sure when that was. But it's been maybe two or three years.

Q Does anyone else in your household smoke?

A No.

Q And are you saying that the two to three cigarettes you smoke a day has been a routine since you were 15 or 16 years old?

MR. BASSETT: Object to the form of the question.

A That's been the general routine, just smoking two or three.

Q (BY MR. ALLEN) Do you -- well, what kind do you smoke? What brand?

A Cools.

Q What other brands have you smoked over the years, or has that been your brand since you started?

A Years ago when I was a teenager in high school, it seems like I remember smoking some Winstons.

Q But other than that, it's been pretty much Cool all the way?

A Yes.

Q Have you ever tried to stop smoking for an extended period of time?

A Yes.

Q And how many times?

A Once, that I recall.

Q And when would that have been?

A This was from about '59 or '60 when I - about the time I graduated from high school, until I went back to college full time in 1964.

Q So you were able to quit for four years, approximately?

A Yes.

Q Why did you start back?

A I started back to college, and I just wanted to start smoking again, so I did.

Q Have you made any attempts since 19- -- you beginning again in college in 1964 to stop smoking?

A No. I've had times when I didn't smoke or might go several days without smoking, but no attempts to say I'm going to quit from now on.

Q You mentioned the word "chipper." Where did you learn that word?

A It's in the literature that I read, and it's often applied to cocaine use. But I've heard people refer to it with smoking as well. And it's where the -- as with cocaine, for example, it's where they just use it periodically and don't develop a regular use pattern for the drug or the cigarettes.

Q Do you take any other type of medications?

A I take an aspirin every other day,

three hundred and twenty-five milligrams, again for cardiac prophylaxis. I take Atenolol, A-T-E-N-O-L-O-L, which is what they call a beta blocker, for the same reason. It's twenty-five milligrams a day.

Q Have you had heart problems?

A No. It's for the same reason, that based on the literature that it helps not only prevent a second heart attack after you've had one; it helps prevent a first one. So I treat it myself.

Q But, I mean, you never have been diagnosed with any propensity for having heart problems? You're just doing this strictly as preventive measures; is that correct?

A Yes.

MR. BASSETT: Object to the form.

Q (BY MR. ALLEN) Have you had any other -- have you had any other illnesses that you or your physician has attributed to the smoking?

A No.

Q Have you ever been told by your physician to stop smoking the two to three cigarettes a day?

A No.

Q When you go to your medical doctor and fill out the forms that we all have to fill out -- and I assume y'all aren't immune from that -- do you fill out that you're a smoker or non-smoker?

A Well --

Q I don't think there's a category for chippers.

A Unfortunately, like a lot of physicians, I don't seek a lot of medical care. I've been very healthy. I'm in good health. I check my -- I do a lot of primary care myself. I have the ability to draw blood, do EKG's, et cetera, so I do a lot of checking of myself. I do an EKG and a blood chemistry once a year.

I have gone to physicians periodically for like a barium enema and so forth. I draw my own PSA's annually to

check for -- to screen for prostate cancer and so forth.

And I really don't have a regular physician that I go to and have a regular record in his office and so forth.

Q Well, I mean, for example, the time you went for the barium enema, do you have to fill out any forms where they ask you whether or not you smoke cigarettes?

A I don't recall that question.

Q Have you ever been asked that question on any forms that you filled out, insurance or otherwise?

A Yes.

Q And what do you say on the insurance forms where they ask you whether you're a smoker? Do you say yes or no?

A Well, it's been a long time since I've done an insurance form, and I don't recall. I don't recall -- I do know I don't have preferred rates.

Q If I put a form in front of you today for the application of insurance, what

would you put down if the question says, Do you smoke?

A If you ask do I smoke?

Q Yeah.

A I would say yes.

Q Do you know if your health insurance carrier rates you as a smoker or a non-smoker?

A I don't know.

Q Does anybody else in your family smoke? I may have asked you that question.

A In my immediate family?

Q Yes, sir.

A No.

Q Well, do you have, I don't know, brothers or sisters, close relatives, who do smoke?

A Well, I know one brother that I know used to smoke, but I haven't seen him in years. I know I have a brother in South Carolina that's two years younger than me that used to be a regular smoker, and he quit several years ago and hasn't smoked

since. I have an older brother who I haven't seen in years who used to smoke, so I don't know his current smoking. I have three sisters. None of them smoke. And my father was a smoker. My mother wasn't.

Q And is your father still alive?

A He died at 81.

Q What did he die from?

A Pneumonia and septicemia.

Q Did you feel like it was related to smoking?

A No.

Q Have you ever in your practice told any of your patients that they needed to stop smoking?

A Well, I can't recall any specific patients, but I have had patients to talk about smoking and that they've been told they should stop. And I would re-enforce that, that they should stop.

Q Why would you as a medical doctor tell your patients to stop smoking?

A Well, one patient that I can think

of right offhand, for example, has coal miner's lung, coal miner's disease, and some asthma. And he was told to stop smoking, and I re-enforced that.

And since there's -- based on my medical training and rescanning over some of the medical literature, which I do routinely, even though it may not be my field -- that is not my field. There's a statistical -- appears to be a statistical correlation between cigarette smoking and certain diseases, like pulmonary disease, which he already had. So I assume that would not be the best thing for him to do, not take any chances of making it any worse in any way.

Q. Other than this one person that you've told me about, in all the years you've practiced as a psychiatrist have you ever recommended that any of your patients stop smoking?

MR. BASSETT: Object to the form of the question. Asked and answered.

Q (BY MR. ALLEN) You can answer it again.

A Yes.

Q Sir?

A Yes, I have.

Q How many times would you say you've done that?

A I really don't know, because in the process of seeing my patients as a psychiatrist, it would come up -- the issue of smoking would come up as a tangential issue, if you will. I haven't had patients to come to me and say, I'm hooked on cigarettes or whatever. I want to get off. And -- but they would present that as just something much like they would say I need to lose weight or I need to exercise more. And I will usually re-enforce that just like I would with the weight loss or exercise.

Q But can you give me a ball-park figure of how many folks you've told they need to quit smoking?

A You mean total number since I've

been in practice?

Q Yeah, if you know.

A Maybe a hundred, a hundred and fifty.

Q Did you ever tell any of those folks they needed to quit smoking because it could adversely affect their health?

A Well, again, like I said, in the process of doing psychiatric evaluations and taking a history of the patient, I do ask about drug and alcohol abuse. I do frequently ask about smoking. Sometimes they volunteer that they don't use drugs, alcohol, or smoke. I don't have to ask them.

But the situation usually doesn't come up that I can recall, that I would specifically state because they say they do smoke that you should stop smoking. I would usually take their lead and follow them with that, if they've been told that by their primary care physician, that they should not smoke.

Q Well, let me just be sure I understand. You've never told any patient who comes to you and said, My primary care physician said I ought to quit smoking, and told them, Don't worry about it; you need to keep smoking?

MR. BASSETT: Object to the form of the question.

Q (BY MR. ALLEN) You wouldn't tell them that, would you?

A No, I wouldn't.

Q Have you ever told any of your family members or friends for health reasons that they ought to stop smoking?

A My father.

Q And when did you tell him that?

A It was before he died.

Q And why did you tell him that he needed to stop smoking?

A I thought he was smoking too much. And he would just sit in the house after he retired and smoke and watch television.

And, again, as a physician and

knowing what I do about the statistical association between smoking and various diseases, like coronary artery disease and so forth, I just felt the need to tell him as a physician and as a son that he should at least try to cut down on his smoking.

Q And did he quit smoking before he died?

A No.

Q And how many cigarettes did he smoke a day?

A I don't know, but I would estimate a pack and a half to two packs a day.

Q For how many years?

A As far back as I remember.

Q Tell me basically -- and I've got the Rule 26 information -- what your opinions are in this case, Dr. Patterson.

MR. BASSETT: Let me object to the form. It's kind of broad. But with that, Dr. Patterson can answer it.

A Yeah. Could you be a little more specific.

Q (BY MR. ALLEN) Well, I really want -- I know you were consulted to testify in this case and -- show me the Rule 26 information. That might be easier.

A The disclosure?

(Plaintiff's Exhibit B was marked for identification.)

Q Yes, sir. And I'll just label this Plaintiff's Exhibit B. And yesterday you said you met with three attorneys, I believe, to discuss your testimony?

A Yes.

Q And who are those three attorneys?

A They're present here.

Q The same three we have here in the room?

A Yes, sir.

Q How long did y'all meet?

A Three and a half hours.

Q Three and a half hours. Did y'all discuss what your opinions were going to be in this case?

A Yes.

Q That's what I want to find out; basically, what you intend to tell the jury about smoking and health or smoking and addiction. And all I have been given about your testimony is what I have now labeled as Plaintiff's Exhibit B. And if you want to refer to that or your memory from your discussion yesterday, that will be fine.

MR. STUHAN: Object to the question. I believe it calls for a narrative answer.

MR. ALLEN: Nothing wrong with that.

MR. STUHAN: There sure is.

A I -- we discussed the Acton case. Primarily, Buren -- Jimmy Acton's wife, Buren Acton. And that's what we discussed.

Q (BY MR. ALLEN) Tell me what y'all discussed, then.

A Well, we discussed the psychiatric -- primarily, the psychiatric aspects of her case. Things like her smoking behavior, the probability that she

could stop smoking. Things like this.

Q Is that it?

A We talked about the difference between addiction and dependence. We talked about evaluation of patients who might be dependent or -- even though it's not a medical term, in my opinion -- addicted to drugs, how they would be evaluated psychiatrically.

We talked about the DSM-IV, which is the -- our psychiatric diagnostic and statistical manual.

Q Do you believe that DSM-IV is a standard and authoritative text?

A Yes.

Q Go ahead.

A And we talked about the DSM-IV criteria for substance abuse and nicotine use disorders.

Q Does that pretty well cover it broadly?

MR. BASSETT: Object to the form of the question.

A Yeah.

Q (BY MR. ALLEN) Look at what I've marked as Plaintiff's Exhibit B. Let me look at it, and I'll show you what I'm talking about.

It says that Dr. Patterson is expected to testify about the smoking behavior of Buren Acton. His testimony is also expected to include the assessment of addictive behaviors generally, a general analysis of cigarette smoking and addictive behavior, as well as an analysis of smoking cessation.

Tell me what you are going to tell the jury about that area.

MR. BASSETT: We object to the form of the question being compound.

Q (BY MR. ALLEN) And if you want to look back at it, there's your --

A No, that's okay. We talked about Ms. Acton. And in reviewing her, I had a -- in reviewing her depositions, this gave me a good picture of her personality, her smoking

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behavior.

She started smoking when she was 18 years old, smoked a variable amount of cigarettes over time. It wasn't quite clear. It was fairly inconsistent from the deposition exactly how much she did smoke.

It was very clear from looking at her as a person that she had a strong work ethic; that she was a strong-willed woman, based on several incidents that had occurred in her life, like walking on a crushed leg after a car accident in '59 when the doctors told her she would never walk again; getting herself removed from the hospital and refusing to take Valium from a -- what she called a quack doctor in 1966 and making her family take her out of the hospital; working two jobs for over fifteen years. And she obviously had a strong ethic and was a strong-willed woman.

In terms of her smoking, she made it very clear that she smoked because she wanted to. The only time that -- except for

that brief hospitalization which just was a few days, I believe. Maybe up to a week at the most. There was anywhere from a three to six weeks period after April of '95 when Jimmy Acton, her husband, was diagnosed with lung cancer that she stopped smoking for a three- to six-week period of time.

She then resumed smoking, in my opinion, because she wanted to at that time, and as far as I know, continues to smoke today.

And my opinion was that Ms. Acton in view of her personality, her ability to do things that -- when she sets her mind to it -- she talks about this several times in the deposition. If she had the motivation and the desire to stop smoking, that she would be able to.

Q Do you believe she is addicted to nicotine?

A No.

Q Do you believe anyone is addicted to nicotine?

A I have not seen any patients that I felt met the criteria for being addicted to nicotine.

Q Do you believe cigarette smoking and nicotine is an addictive -- strike that. Do you believe that cigarettes are addictive?

A Cigarette smoking is a complex behavior. I believe it is very much state related. It's related to socialization, drinking coffee, happy hour, parties, and so forth.

And in my opinion, I don't believe nicotine or cigarettes meet the criteria for -- and, again, I would not normally use the term "addictive," -- but meet the criteria for physiologic drug dependence.

Q Well, does that mean that you do not believe cigarettes are addictive?

MR. BASSETT: Object to the form of the question. Asked and answered.

A Yeah, I -- I thought I answered that. Addiction is not normally a --

considered to be a medical term even though even physicians will use the term in order to communicate with other people who are not in medicine.

But we usually use the term "dependence." The DSM-IV uses the term "dependence" and not "addiction."

And in my opinion, cigarettes and nicotine do not meet the criteria in any of the patients that I have seen for dependence as listed in DSM-IV.

Q (BY MR. ALLEN) What is your definition of addiction?

A Well, like I said, I don't usually use the term "addiction." But to me it's more -- and there's -- you can read a lot of different papers on the definition of addiction.

But to me it's a sociolegal term. It implies that you have an individual who has a pattern, an obsessive pattern, of drug use or abuse that occurs on a -- usually a constant or daily basis; that it preoccupies

the majority of their time either using the drug or seeking ways of obtaining the drugs.

It -- there's an implication, although it's not always true, that these patients are physically dependent on whatever drug that they're using. And in this case, it's usually drugs like cocaine or heroin or opiates or narcotics like this.

And these patients will spend a lot of time trying to obtain the drug. They become high on the drug. They develop tolerance to the effects of the drug, and they exhibit withdrawal symptoms if they stop the drug. And it usually causes impairment or a change in their lifestyle, whether it be social, occupational, marital, or some other important aspect of their life.

Q Now, where did you draw that definition from?

A This is drawn from my reading of

the literature, my experience. It's drawn from various articles that I've read on addiction.

Q Did you bring those -- I'm sorry. Did you bring those articles with you?

A Well, I did bring the 1964 report where the Surgeon General differentiates between addiction and a habit.

Q That's fine. Any other literature that you brought with you that supports that opinion?

A No.

Q Do you have any other literature that the -- you mentioned the literature that was at your office that was sent to you by the tobacco lawyers?

A At my home.

Q I'm sorry. But are there articles in there that support the definition of addiction that you just gave me?

A I believe so, yes.

Q And --

A Maybe not exactly every -- every

word.

Q Did you rely on that information to confirm or support your opinion of the definition of addiction?

A Well, in scanning these articles, the articles basically was in conformity with the opinion that I just expressed.

(Plaintiff's Exhibit C was marked for identification.)

Q Just for the record, you brought the Smoking and Health Report Of The Advisory Committee To The Surgeon General Of The Public Health Service. And when was the date of this article -- I mean the -- its publication?

A It should be '64.

Q 1964. Do you have any other articles with you that would support the definition of addiction that you just gave?

A No.

Q Does the definition of addiction that you just gave me differ from what's contained in the DSM-IV that you have in

front of you?

A Well, like I said, the DSM-IV does not mention addiction. There's no criteria or anything listed in the DSM-IV. It's only dependence.

Q The Rule 26 information indicated that you were supporting the opinion by review of scientific and medical literature and review of relevant Surgeon General's reports and other materials.

Do you have -- tell me what literature and Surgeon General reports you are relying on.

MR. BASSETT: Let me object to the form of the question. It's vague and ambiguous when you say relying on for which of the opinions listed in the Rule 26 disclosure.

MR. ALLEN: That's a fair objection.

Q (BY MR. ALLEN) But as far as -- is there -- can you tell me, I guess, what literature you can point me to to support

your definition of addiction that you just gave, other than obviously Exhibit C?

A Well, I can't cite any specific articles. But I do have these articles in my teaching files and at home.

Q And could you readily pull those out?

A Not readily, but I could.

Q Not a good word. Could you get a hold of them pretty easy?

A I could get a hold of them.

Q Is there any other literature that you brought with you to support that definition today?

A No.

Q Show me in Exhibit C the definition that you just gave me.

A Here.

Q You've directed my attention to page 351.

A That's the comparison chart. And then it goes into some more detail in the text.

Q What is it that -- first of all, you said that, I believe, cigarette smoking does not meet the definition of addiction as contained in this report; is that correct?

A That's correct.

Q And what is it that is not seen with cigarette smokers that would meet the criteria of addiction?

A Well, that's what this report is about, is it's differentiating between addiction and habituation and comes to the conclusion that cigarette smoking -- doesn't really talk about nicotine that much in this particular part. It does mention it. But that it better fits a habit than an addiction.

Q Have you reviewed any of the subsequent Surgeon General reports relative to addiction in nicotine?

A Yes.

Q You have?

A Yes.

Q And do you disagree with the more

recent Surgeon General's reports on their opinion with respect to the addictiveness of nicotine?

MR. BASSETT: Let me object to the form of the question as far as identifying which of the other Surgeon General reports.

Q (BY MR. ALLEN) You can answer.

A The one I'm most familiar with is the '88 report, which is -- which was a report by the Surgeon General in 1988 where it basically proclaims that nicotine -- based on the evidence that whoever prepared this report reviewed, they came to the conclusion that nicotine was the compound or substance in cigarettes that causes patients to become addicted to cigarette smoking.

Q And my question is: Do you disagree with that Surgeon General's report?

MR. STUHAN: Well, I object to the question with the absence of some specification of particular conclusions of which the witness may or may not agree.

I think your question that asks him if he agrees or disagrees with a three to four hundred page document is impermissibly vague and ambiguous.

MR. ALLEN: I thought we were talking about nicotine addiction. But that's what I was asking about.

A I don't have any personal knowledge or research or whatever that nicotine is the substance that would lead people to smoke.

As I say in my disclosure, this is a complex behavior. People smoke for various reasons. They have a lot of different smoking patterns. And a lot of patients stop smoking without any sequelae. They -- ninety-five percent of them who do stop, stop without any aids or assistance whatsoever.

And this does not characterize most of the drugs that I'm familiar with of abuse, like the opiates and the narcotics and cocaine and heroin and so forth.

And so, therefore, I don't have any personal knowledge that nicotine is the cause of why people are addicted to cigarettes.

Q (BY MR. ALLEN) I'm sorry, I didn't catch that last sentence.

A I don't have any personal evidence that --

Q That --

A -- that nicotine is the reason why people smoke or is the cause of addiction.

Q And, therefore, do you draw from that a conclusion that nicotine is not a drug that causes dependence or addiction?

MR. BASSETT: Object to the form of the question.

A I would like to refer to the DSM-IV, if I may. And if you look at the DSM-IV, based on -- and, again, they don't talk about addiction at all. But on page 105 in the small DSM-IV, the reference book, it lists nicotine as having two characteristics of the abusable drugs that

they list here, along with caffeine, pot, cocaine, inhalants, opiates, and so forth. And one of them is dependence and withdrawal.

And then under the -- on page 106 and 107 it lists no substance-induced disorders that we see in psychiatry related to nicotine, like dementia or intoxication, anxiety disorders, mood disorders, sexual dysfunction, and so forth.

And then on page 108 where it lists for all the substances of abuse that they list in the DSM-IV, it lists the criteria for substance dependence.

And then on page 133 it lists the nicotine-related disorders, which is dependence and withdrawal. And then it lists the criteria for withdrawal.

So this is the guide that I use in assessing and would use in assessing someone who I felt might be dependent on nicotine. And I have not seen any patients who meet these criteria.

Q (BY MR. ALLEN) Well, do you think -- why do you think they have that in the DSM-IV if they didn't think it was a possible problem?

MR. BASSETT: Let me object to the form of the question. Vague and ambiguous.

As you know, the DSM-IV is a handbook listing the criteria for the various psychiatric disorders. And most psychiatrists use it as a guideline. And this is a guideline after doing an assessment, a psychiatric evaluation, and so forth. And it doesn't necessarily mean that I believe or totally accept everything that's written in this book.

And it also, I think, is subject to some social, political, economic, and other pressures in what's contained and not contained in this.

For example, when I was a resident, homosexuality was listed as a psychiatric disorder in the DSM. And then due to social pressures and whatever, this

was taken out. And that's no longer -- it is no longer like -- just like that. It's not a psychiatric disorder.

Q (BY MR. ALLEN) Well, who writes the DSM-IV?

A The DSM-IV is written by the American Psychiatric Association based on the work review of the current literature, consensus of opinion of task forces and committees for each disorder, like eating disorders. You know, the broad disorders. Psychotic disorders, mood disorders. And then they write the criteria based on that committee and task force work.

Q And how long has the DSM -- I know there was a DSM-III that predates the IV. How long has it had a category for drug dependence for nicotine?

A I think it was DSM-IV.

Q You don't think the DSM-III had it?

A I don't believe the DSM-III. The DSM-III-R may have had it listed, but I

don't recall it being listed as nicotine dependence.

Q Have you ever written the American Psychiatric Association and told them that you disagreed with their including nicotine dependence in the DSM-IV?

A No.

Q Are you aware of a segment, I guess, of psychiatrists who believe that -- like yourself, that it ought to be not included in the DSM-IV?

MR. BASSETT: I'll object to the form of the question. Characterization of prior testimony.

Q (BY MR. ALLEN) You can answer.

A Based on discussions I've had with other psychopharmacologists like myself and based on articles that I've read, there's quite a few psychiatrists and psychopharmacologists who feel nicotine does not meet the criteria for a drug that produces dependence or withdrawal, as stated or listed in the DSM-IV.

Q Can there be dependence without withdrawal?

A Well, it depends -- it depends on what criteria you're using.

Q Are there certain addictive drugs that do not have withdrawal symptoms?

A Addictive drugs that don't have -- you mean drugs that cause dependence?

Q Yeah, true.

A Usually most psychopharmacologists would agree that the major criteria for dependence is if the drug is dramatically reduced in dose or if it's withdrawn abruptly, they will have withdrawal symptoms. And that is sort of the accepted evidence that they were physically dependent on the drug.

Q And is it your testimony that nicotine; in particular, nicotine from tobacco smoke, has no withdrawal symptoms?

A Well, if I could refer back to the DSM-IV.

Q Sure.

A On page 133 or section 292.0 Nicotine Withdrawal, it says, Daily use of nicotine for at least several weeks, abrupt -- B, is abrupt cessation of nicotine use or reduction in the amount of nicotine used followed within one day, or twenty-four hours, by four or more of the following. And they list, I believe, eight things. And it's dysphoric or depressed mood, insomnia, irritability, frustration or anger, anxiety, difficulty concentrating, restlessness, decreased heart rate, increased appetite, or weight gain.

And then under C it says, These symptoms in Criterion B must cause clinically significant distress or impairment in social, occupational, or other areas of functioning.

And then lastly they always say it can't be due to some other medical condition.

And one of the criticisms I have, and I believe other psychopharmacologists

have and other psychiatrists would have, is that these are very vague symptoms. These -- this is not like the somatic withdrawal symptoms that you would see, for example, with alcohol withdrawal, DT's; that you would see with opiate withdrawal where you have goose flesh, lacrimation, rhinorrhea, abdominal pain, where you can almost look at their symptom complex and it's so familiar. It's so -- I mean, it's so common in each patient that's withdrawing from that drug that you can almost diagnose what drug they're withdrawing from by just looking at their symptoms.

These are symptoms that are very common even in the general population, and we feel -- I feel they're much too vague.

And if you look, for example, at Ms. Acton's case at the time that -- the three- to six-week period if -- depending on who you read in the depositions. We figure it's at least three weeks that she stopped smoking. The only thing that was really

talked about was some anxiety. And even then she didn't appear to tie that to the stopping smoking itself, but to -- and, of course, in the deposition they don't call it anxiety, but nervousness. She was nervous during that period according to her and her husband.

And she talked about some irritability, but she -- that was mostly at work. And she did not attribute that to the fact that she had stopped smoking.

Q The question I have, though, is do you believe or can you point to any research that would indicate that the folks who wrote the DSM-III were wrong with respect to the withdrawal symptoms and dependence on nicotine?

MR. BASSETT: Let me object to the form of the question. You said DSM-III.

Q (BY MR. ALLEN) I meant IV. Excuse me.

A If I understand your question, you're asking me do I believe that the

people who wrote this section on nicotine withdrawal, that they were wrong?

Q Yes, sir.

A Okay. I disagree that this is a discrete -- normally when you look at a withdrawal syndrome from drugs of abuse, you see a discrete somatic withdrawal symptom. And I disagree that these are discrete enough to really be acceptable as a withdrawal syndrome.

Q Does that mean they don't exist?

MR. BASSETT: Object to the form of the question.

Q (BY MR. ALLEN) When you say discrete, I don't understand what you mean by that.

A Discrete would mean that it would be particular symptoms related to a particular -- withdrawing from a particular drug, like I listed a while ago for opiates.

Q Okay.

A And then, of course, DT's is well documented in the medical literature as a

withdrawal syndrome from alcohol, and it's very recognizable by any medical doctor who's ever seen it.

Q Are you saying that everyone that's dependent on alcohol will have DT's?

A No.

Q Aren't there some occasions when alcoholics do not have DT's at all or any of the symptoms but are still dependent on alcohol?

A Well, you know, we were talking a while ago that drugs of abuse and the patterns of use, the sequelae that occur after the patient stops or decreases the use of that drug, is very variable.

You can have patients stop drinking after a long period of time and have almost no symptoms. You can have others who will go into DT's. You'll have others who would be in between.

There's many people who have stopped smoking cold turkey with almost no sequelae at all.

In Ms. Acton's case, about the only thing I could really definitely list as a withdrawal symptom, according to the DSM-IV, would be nervousness.

Q What about weight gain?

A Well, in looking at her records, her medical records, her weight was about two forty or so. And I think she had gained some weight over time. But, again, to my knowledge, she never made a serious attempt or was motivated to make a serious attempt to stop smoking for a significant period of time for weight gain to show up. So --

Q Are you discounting her testimony?

MR. BASSETT: Let him finish if he hasn't finished.

A So her weight, as far as I'm concerned, was fairly heavy. But as I understand it, she was relatively tall and could carry the weight fairly well even though she weighed over two hundred pounds.

But she was listed -- she was listed, and I think in one -- at least one

of the medical records, as being obese. And this was back in the '80s.

(Whereupon, a break was taken.)

Q (BY MR. ALLEN) When we took a break, I was asking you about, I guess, the symptoms of withdrawal syndrome from nicotine. And I think you said you discount -- or do you discount Ms. Acton's testimony where she said she gained weight when she tried to quit smoking?

A Well, this is the kind of thing I'm talking --

MR. BASSETT: Let me object first to the question on the characterization of her testimony. But I'll let Dr. Patterson answer.

MR. STUHAN: I'm going to object to the question, too, on what I guess is the related ground that I don't remember that testimony. It would be helpful, I think, to pull out the transcript of the deposition and show Dr. Patterson specifically what you're talking about. He has it here.

Q (BY MR. ALLEN) You can answer the question.

A Yeah, I don't recall her saying in the deposition that she gained weight because she quit smoking.

Q What about her appetite? Do you recall her saying anything about her appetite increasing?

A No.

Q You don't? And you were looking at this to see if she had withdrawal symptoms -- looking at her deposition?

A Well, yes, I did look for that. And I didn't see --

Q You don't remember that?

A -- her saying, I stopped smoking for three weeks, and I was anxious and nervous and I had increased appetite and I gained weight.

Q You don't remember that at all?

A No.

Q Well, if she did say that or implied that she would eat a jackass if it

came in front of her, would that be one of the symptoms contained in the DSM-IV of alcohol -- excuse me -- nicotine withdrawal?

A If you accepted that as a withdrawal symptom, it says --

Q The question is: Is it a symptom?

MR. BASSETT: Object to the form.

A Increased appetite or weight gain is a symptom of withdrawal of nicotine according to the DSM-IV.

Q (BY MR. ALLEN) Thank you. What other symptoms did you look at and rule out in her case based on her deposition testimony?

A I looked at all of them.

Q Well, tell me which ones you ruled out.

A She didn't talk -- she didn't say anything about difficulty sleeping. She was still working two jobs. And one as a dispatcher for a police department. And the other was like as a communication secretary. And I think she worked a shift,

like, each Saturday or each every other Saturday, and then she sort of rested on Sunday.

Q So from that you ruled out insomnia; is that correct?

A Well, there was no mention of it whatsoever.

Q And that's my question. Is that what you used to rule out insomnia?

MR. BASSETT: Object to the form of the question.

A Well, she did not complain of insomnia. She didn't talk about that as being a problem. And I -- at the time her deposition was being taken, this was done by an attorney. Those questions, as I recall, were not asked specifically. She wasn't being interviewed by a psychiatrist asking specifically for withdrawal symptoms.

Q (BY MR. ALLEN) I understand that.

A So --

Q It's hard to make a diagnosis without talking to the patient, isn't it?

MR. BASSETT: Object to the form.

A Well, I think you can determine if you have enough information -- regardless of who gathered it, you can give opinions and make a determination if a person, for example, meets certain criteria in the DSM-IV for a particular psychiatric disorder, ideally.

And this is the way I conduct my practice. I see a patient. I talk to them. I review medical records. I take a history. I do a mental status exam. And I may talk with family members before I reach a diagnosis.

Q (BY MR. ALLEN) So do you feel like you need some more information about -- and more detailed questions about whether or not she experienced insomnia during the period of time she tried to quit smoking?

A You mean as to whether or not she had it?

Q Yes, sir.

A Or whether or not she was in

withdrawal?

Q Whether or not she had insomnia.

A If she didn't mention that she didn't have insomnia, I would assume that she didn't have insomnia.

Q What would you ask a patient, though, to determine if they had insomnia, if the patient was sitting in front of you?

A My first question would be is how are you sleeping.

Q Would you follow up with other questions?

A Or how is your sleep.

Q There are a lot of reasons why people don't sleep. Isn't that true?

A Yes.

Q So you've got to do an in depth discussion to determine if it's really insomnia or not, don't you?

A Yes. And this is exactly the reason why I don't like -- and this was the criticism, reflecting back on the criticism I had earlier, of these symptoms.

A lot of people report insomnia. If you look at patients over 65, it's almost universal. But that doesn't mean they're in nicotine withdrawal. And this is the problem I have, in that this symptom is very common in the U.S. population.

Sleeping pills is one of the most common drugs that are used by the elderly, over 65 population. Over-the-counter medications for sleep are used by many, many people.

Q Well, are you saying here today you can say she did or did not have insomnia as a symptom after she tried to quit smoking?

A In my opinion, from reading her deposition and getting a good feel for her personality, her ability to be very outspoken, I think if she had difficulty sleeping, she probably would have mentioned it.

Q So you feel comfortable with that?

A I feel fairly comfortable.

Although, if you wanted me to bet my life on it, I would want to ask her specifically.

Q Let me ask about this other -- the symptom category, dysphoric or depressed mood. Can you tell me whether you can rule in or rule out that based on her deposition testimony or any other information you have on Ms. Acton?

A Ms. Acton during that period of time -- and, again, we're talking about a relatively brief period of time. Best I can pin it down is three to six weeks. She continued to work the two jobs. She didn't stay out of work at all. She was not ill at the time. She didn't identify herself as being impaired. There was no evidence that the sheriff's department sent her home because she wasn't functioning properly or because she wasn't interacting with people properly.

She was a dispatcher. You have to use a lot of concentration to be able to remember numbers and codes to dispatch

sheriffs out to certain locations, et cetera.

And, therefore, I didn't feel any of these really were documented or were present at the time, except mostly the nervousness. And, again, she didn't relate that back to the stopping smoking.

Q. Let me ask you this, though: What are the symptoms of dysphoria or depression?

A. The symptoms of depression are some of the things that are contained in here. And if you look at the symptoms in the DSM-IV, you have to have several -- you have to meet several criteria.

One is you have to have a depressed mood. Sad, blue, down in the dumps every day for two weeks or longer. Or you -- since some patients deny that they're depressed, you have to have anhedonia, or a loss of interest in your usual activities.

And then you have to have -- it's, like, five of the eight mostly vegetative symptoms. And it's basically sleep or

insomnia; anhedonia or decreased interest; a feeling of guilt, that you've committed sins or whatever in your life; decreased energy; decreased concentration; a change in your appetite. It's usually decreased, but it can be increased.

Q Would you --

A And then suicidal thoughts. And that's how you diagnose it.

Q As a psychiatrist, you don't just sit somebody down and ask them, Are you depressed, to make that diagnosis, do you?

A No, because that would be asking them to make that diagnosis. But I ask them how they've been feeling, how they've been functioning, and what symptoms they've had. And then I start putting it together.

Q It has to be an in depth examination to determine if somebody really is depressed; isn't that correct?

MR. BASSETT: Object to the form of the question. Vague and ambiguous.

A Well, when I interview a patient,

I will start generally, and then I'll narrow down to specific symptoms. Like I might say, How is your sex life? And then if they say, Well, it's terrible, well, obviously, that doesn't tell me anything, so I would have to go further to ask specific questions. What do you mean by terrible? And then keep going from there.

Q (BY MR. ALLEN) Sure. How did you interpret Ms. Acton's testimony, when she did quit for that brief period of time, where she said she didn't want to be around people anymore?

A I do remember her making that comment. I think it was -- she related it mostly of work. And -- but she didn't relate it to the stopping smoking. And she described herself of being that way before.

Q So you discount that --

A Of getting irritable with people at work for not knowing what they're doing or sort of being stupid or whatever. And I think she saw herself as a very competent,

hard working person. And she seemed very intolerant of someone who didn't have the same values.

Q Well, did you discount that testimony as being in any way related to her cigarette smoking and the fact that she had quit?

MR. BASSETT: Object to the form.

A Yes.

Q (BY MR. ALLEN) You did not relate it; is that correct?

A I did not because she didn't.

Q And one of the other symptoms is decreased heart rate. How would you determine that in a patient?

A I would measure their pulse at the radial artery in the wrist.

Q You wouldn't expect a patient to know whether their heart rate is increased or decreased, would you?

A I don't think so, unless it got so low that they fainted. And even then, they may not know what their heart rate is unless

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they're medically trained and know how to measure it.

Q You said that you did think that she had some anxiety based on the time that she quit smoking. How did you determine that?

A Well, I think the question was asked about during that period of time how did she feel. And it was -- it was definitely, I think, asked of Mr. Acton. And he said -- and she did too -- said that she was nervous.

Q How do you distinguish nervous and that testimony, I guess, from the symptoms that they list in the DSM-IV of restlessness or impatience?

A Well, I wouldn't list those two -- those two or three together. But I would equate nervousness with anxiety, which most lay people don't use anxiety. They say nervousness. So lots of times we'll use it too.

Q Do you believe anyone based on,

again, your experience becomes dependent on nicotine in cigarettes?

A I have not seen any patients that I've come in contact with or in my practice that I felt met the criteria for dependence on nicotine or cigarettes.

Q What is it that you believe causes people to continue to smoke, even those who say they want to quit smoking?

A It's like I said a while ago. I see smoking, much more like the 1964 Surgeon General's report, as a habit. It's a -- what we call in psychiatry, a state-dependent activity, in that patients tend to smoke in social situations, at happy hour with the guys. They smoke with coffee. They smoke while drinking. They smoke after having a good meal.

In my case, I tend to smoke at night outside on my patio. And I rarely think of it unless I'm in that state or that situation.

And I think, like I said, it's a

very complex behavior. There's a lot of socialization involved in smoking. You have smoking bars in hotels and so forth for people to congregate and talk and socialize and smoke cigars and cigarettes. And so it's a very culturally, socially-bound type of behavior. And this, I think, is a very significant determinant of the smoking behavior of a lot of people.

But, again, everybody is different. Everybody in their smoking patterns are different and so forth. So you would have to look at each case individually to determine, you know, just what their smoking pattern was.

In Ms. Acton's case, it was clear that she wanted to smoke. She made it very clear that she wanted to smoke in her house. She generally did it, even though she would observe her husband's admonition that she smoke in front of him. And he might raise a window or something, and she might put it out or go to another room. But

she felt this was my home, this was my castle, I can smoke here if I like. And so in her case she made a determination to smoke. She continued smoking the whole time.

In one of her medical records the physician, I think, listed her as having a forty-year pack history, which is about consistent with the intake that she said she had. She had done that since age 18.

And so in looking at her, I would say this is a woman who smoked because she wanted to. She had control over the behavior, as evidenced by the fact that she could go up to a fourteen, sixteen-hour work period without a break.

She -- I can't believe she did this, but she actually stayed in her deposition. She sometimes would want to get a break. They passed a rule five years prior to the deposition that she couldn't smoke at work. And she didn't. And you would expect her to obey that rule, because

that's the type of person she was. And she could go twelve, fourteen, sixteen hours without smoking a cigarette because she had very strong will. She knew she wasn't supposed to, and she didn't do it.

And then when she had the opportunity to smoke, she made the decision that she was going to smoke, and she did.

Q Do you agree or disagree with the information in the DSM-IV that indicates that in the United States between fifty percent and eighty percent of the individuals who currently smoke have nicotine dependence?

MR. STUHAN: Can we have a page reference to that?

Q (BY MR. ALLEN) Page 246. If you want to look at it, you're welcome to.

A Is this where you've got the red arrow?

Q No, sir. Let me show you where I'm talking about. Under Prevalence. And there's a lot of stuff about how many folks

smoke and all that, but I'm asking you about the sentence that talks about fifty to eighty percent of people that smoke have nicotine dependence.

A Okay. And what is your question?

Q Do you agree or disagree with that statement?

A I disagree with that statement.

Q Thank you. Do you have any literature that will support your opinion that -- where you disagree with the DSM-IV?

A Yes, they're on document. They're on criteria as listed.

Q Do you have any publications independent of that that would support that conclusion?

A I've never read anywhere where someone has evidence or data that there's so many people dependent on nicotine or tobacco, because it would require an evaluation of each one of these people in a large study involving large numbers of people. And I don't know where they would

even get a number like that unless it's just an educated guess or an estimate.

Q You have not looked for the literature, then?

MR. BASSETT: Object to the form of the question.

A To my knowledge, there is no literature on the numbers of people who are physically dependent on nicotine as when using DSM-IV criteria.

Q (BY MR. ALLEN) Let me ask you this. Looking at the criteria for drug dependence used by the 1988 report of the Surgeon General on Health Consequences of Smoking, Nicotine Addiction, they set out a criteria for drug dependence. And I want you to look at it and tell me where you disagree with their criteria.

A Well, they -- they have some of the criteria there also listed for dependence in DSM-IV. They've also -- they're also adding some things that are sort of accepted but not necessarily listed

like in the DSM-IV, like psychoactive effects. Because in the DSM-IV it just says any -- a mal- -- something like a maladaptive pattern of substance abuse and so forth. They're not really stipulating. It's just assumed.

But they're talking about tolerance, physical dependence. It's just a very general description of dependence. And I don't have any problem with this as for in terms of drug dependence itself. And this is -- this contains some of the same criteria that are listed in DSM-IV.

Q So you think the criteria they use for drug dependence are accurate; is that correct?

A In -- again, these are very similar to what's used in DSM-IV. The difference being -- a very important difference being is that patients who are addicted to drugs as we normally think of addiction, would -- using the sociolegal term, are usually maladjusted. They're not

productive. They're not usually working and so forth.

And then the DSM-IV, this diagnosis requires when it comes to nicotine or any other substance that they have significant impairment in social, occupational, or some other area of their life. And that's what's missing with this particular definition.

Therefore, I would not say this is sufficient to diagnose nicotine dependence in an individual, because I use DSM-IV criteria or would use DSM-IV criteria.

Q Other than that, you're satisfied with the criteria that they used?

MR. BASSETT: Object to the form of the question.

A Well, I really would need to take that list and then match it word-for-word, so to speak, with the DSM-IV to see if they've left anything out.

Q (BY MR. ALLEN) Have you done that?

A But it does talk about -- no, I haven't done that with the '88 Surgeon General's report.

Q Have you read the '88 Surgeon General's report before coming in here today?

A Yes, I stated earlier that I had.

Q And do you agree or disagree with the major conclusions of the Surgeon General that No. 1, cigarette smoking and other forms of tobacco are addicting? Do you agree or disagree with that?

A I disagree.

Q Number 2, nicotine is the drug in tobacco that causes addiction. Do you agree or disagree with that?

A Well, you asked me that earlier, and I know that that was stated. That's the major thrust of the 1988 report. That was not stated in the '64 report. That was a major thrust of the '88 report, identifying or stipulating, proclaiming, that nicotine was the drug.

And I know there's a lot of authorities and people who write on this subject who state that it is the primary drug that is related to smoking behavior when it comes to smoking cigarettes, but I don't have any personal --

Q You've never been shown --

A -- research.

Q I'm sorry. You've never been shown any information about whether nicotine is or is not addicting; is that correct?

MR. BASSETT: Object to the form of the question.

Q (BY MR. ALLEN) Excuse me -- whether nicotine is the drug in tobacco that causes the addiction?

MR. BASSETT: Same objection.

A What do you mean by information?

Q (BY MR. ALLEN) Well, let me ask you this --

A Are you talking about --

Q Well, you've been working for the tobacco companies now for several months.

Have they given you any internal documents that showed whether or not they believed nicotine was the drug in cigarettes that caused people to keep smoking?

MR. STUHAN: I object to that question. There's no evidence of record that Dr. Patterson either now or ever has worked for the tobacco companies. There's evidence quite to the contrary. He's worked for various law firms who represent tobacco companies.

MR. ALLEN: I appreciate that.

Q (BY MR. ALLEN) The question is: Have the lawyers for the tobacco companies during the whole time you worked for them provided you with internal documents by the people in the tobacco companies whether they thought nicotine was the drug in cigarettes that causes people to keep smoking?

MR. BASSETT: Let me object to the characterization of whatever documentation you may be referring to.

MR. ALLEN: I'm not talking about

any documents.

A I don't remember reading any specific document from a tobacco company that nicotine is the reason why people smoke cigarettes.

Q (BY MR. ALLEN) That wasn't the question I asked. The question is: What documents have you been given -- internal documents have you been given by the attorneys for the tobacco companies about that issue?

A You mean on the Acton case?

Q Any case the whole time you've been working for lawyers for the tobacco companies.

A I've reviewed a bunch of literature, a lot of it going back years.

Q I'm talking about internal tobacco documents. People inside R.J. -- do you even know that they exist?

A I have heard about internal documents.

Q Have you asked them for them?

A No.

Q You haven't been shown them either, have you?

MR. BASSETT: Object to the form.

Q (BY MR. ALLEN) Sir?

A Not that I recall.

Q That's fine. The third conclusion by the Surgeon General in 1988 was that the pharmacologic and behavioral processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine. Do you agree or disagree with that?

A I disagree.

Q Now, tell me why you disagree with that.

A Well, I disagree because, like I said, if you look at patients that I've looked at clinically, they're very different from cigarette smokers. The withdrawal syndromes, the compulsive use of the drug, the detrimental effects on them socially, occupationally, and so forth is very

different.

When you look at some of the articles that I've read that disagree with this hypothesis -- and the hypothesis is basically based on the fact that nicotine and cocaine, for example, may have an effect on dopamine, the same neurotransmitter in the brain. But that doesn't necessarily mean that it's just as, quote, addictive or dependence-producing as cocaine or heroin.

And there are articles that contradict and disagree by psychopharmacologists that disagree with this, that it doesn't meet the same criteria and have the same characteristics that these other two drugs have. And it certainly wouldn't fit the same pattern that I've seen in my clinical practice with people who have abused cocaine, heroin, or who are smokers.

Q Do you have any of the literature that you've just quoted with you today?

A No.

Q Could you before trial provide me

with that literature that supports that conclusion?

A Yes.

Q Thank you. If you don't mind, just supply it to the attorneys, and they can supply it to me. Will that be fine?

A Well, they supplied it to me, so --

Q All right.

A And then I have other articles on my own.

Q Well, I need those articles.

MR. STUHAN: Well, the articles that you're inquiring about have already been listed on the exhibit list that we have served and filed in this case, and I don't feel any obligation to do a library research job of materials that are available in the public domain. You can look at the exhibit list and go to the library and get them yourself.

MR. ALLEN: I'm asking for the ones he's looked at, not whatever is in the

public domain.

MR. STUHAN: The ones he's looked at are listed on the exhibit list.

MR. ALLEN: Well, I don't know which ones they are, Mr. Stuhan.

A I have looked at all of them on that list. There was a list of the articles that came in the Fed Ex box that the attorney is talking about. There was a bibliography, if you will, list in each one, and I did look at all of those articles.

Q (BY MR. ALLEN) So there is a bibliography that shows the articles that you've looked at in that package?

A Yes.

Q Do you believe that Ms. Acton had developed a tolerance to nicotine?

A No.

Q And what do you base that on?

A Tolerance is defined basically, in general, as a rather rapid increase in the amount of drug that has to be ingested to give you the same effects that you received

initially.

She started smoking at age 18, as best we can tell, she states somewhere around a pack, pack and a half, for forty-pack years, or up to age -- I think she was age 60 when I read this deposition. So we're talking about forty-two years.

And on the reverse side of that tolerance would be is they have to keep increasing the dose of the drug to get -- I mean, the first one is they keep increasing the dose of the drug to get the same effects. Or if they continue to take the same dose, they don't have the same experience that they had before.

And I don't have any evidence that she didn't get the same pleasure and relaxation. And I think she said in her deposition that smoking relaxed her. And it seemed to still do it in her -- when she was 60 years old.

Q What is the definition of

tolerance out of DSM-IV?

A I just gave it to you.

Q Would you pull it out and read it?

A Yes. Tolerance is defined by either of the following: A need for markedly increased amounts of the substance to achieve intoxication or desired effects.

And by the way, like I told you a while ago --

Q Go ahead and read it, then you can start talking. I want to be sure we've got the definition out of DSM-IV.

A Okay. And B -- and this is either. B is markedly diminished effect with continued use of the same amount of the substance. And that's what I said a while ago.

And what I was going to say is you don't see intoxication with cigarette smoking, or I have never seen it. And this is also listed in that chart that I was telling you about.

Q Did you finish reading the

definition of tolerance?

A Yes.

Q Let me ask you if you agree or disagree with this conclusion out of the 1988 U.S. Surgeon General's report. Number 1, that cigarettes and other forms of tobacco are addicting. Patterns of tobacco use are regular and compulsive. And a withdrawal syndrome usually accompanies tobacco abstinence.

MR. BASSETT: Let me object to the form. It's compounded.

MR. ALLEN: I'm just asking if he agrees or disagrees with it.

MR. BASSETT: I think the conclusions are compound conclusions.

Q (BY MR. ALLEN) Well, if you agree with some of them and disagree with others, that's fine.

MR. STUHAN: I further object to asking questions that were identified as coming out of the 1988 Surgeon General's report without this witness being given an

opportunity to see that statement in context with the 1988 report.

Q (BY MR. ALLEN) You can answer.

A I have said repeatedly that I do not believe that cigarette smoking meets the criteria for addiction. And I also don't use the term "addiction." But I'm using it because you used it. And the Surgeon General used it in his report.

A lot of pharmacologists would disagree with that, as I do, but use the term "dependence."

The other one would be that it's -- it's used on a, I think, consistent or compulsive basis. Certainly regular smokers do smoke consistently on a regular basis. I don't have any problem with that. I've seen that in patients. I've seen that in my father and so forth.

The last one was that it causes a withdrawal syndrome. I've made it pretty clear how I feel about that, that the withdrawal syndrome at least that's listed

in DSM-IV, I would challenge a lot of physicians to recognize this syndrome if seen and try to attach it to any particular drug, because the symptoms are so vague and so common in the general population for many reasons.

Q Are you saying that everybody out there that smokes, then, could stop at any time if they wanted to?

A I feel that any individual who smokes and has sufficient motivation and desire to stop smoking can stop, yes.

Q Well, when you say has sufficient motivation, where do they get that motivation?

A That has to come from within. We know that it doesn't work from the physician. We know that it doesn't work from the spouse, like Jimmy Acton tried to get his wife to stop smoking and would get onto her for smoking. And, obviously, she wanted to smoke, and she smoked.

Q What about all the people that try

to quit and can't quit? Are you just saying they just aren't motivated?

MR. STUHAN: Object to that question.

MR. BASSETT: Object to the form.

MR. STUHAN: It's argumentative.

A I forget all the statistics. But there is significant numbers of people who smoke regularly who quit every year.

I said earlier that ninety-five percent of them quit without any assistance, many of them just cold turkey, the smoking.

Q (BY MR. ALLEN) I'm not talking about -- listen to the question. My question is: For those folks who have tried and can't quit -- the question I'm asking you is tell me why -- is it because they don't have the motivation? Is that your testimony?

MR. BASSETT: Same objections as before.

MR. STUHAN: Object as well, because you interrupted the witness in the

middle of an answer, as you've done repeatedly.

A I don't -- I don't specifically have right on the tip of my tongue or know patients in my practice who have made multiple attempts to stop smoking unsuccessfully. And in order to respond to that, I would have to assess whichever person you're talking about to see what their motivation was. Was it because their doctor wanted them to quit or their husband wanted them to quit? Was it because they've just been diagnosed with cancer?

Q (BY MR. ALLEN) That's not what I asked.

MR. BASSETT: Let him finish the question, and if you disagree with the --

MR. ALLEN: You mean his answer.

MR. BASSETT: Or his answer. Excuse me.

Q (BY MR. ALLEN) Go ahead.

A And --

MR. ALLEN: I'm just trying to get

him to answer my questions instead of his.

Q (BY MR. ALLEN) But go ahead.

A So in order to answer your question about if I feel the motivation is the reason why people who have tried numerous times and cannot stop smoking -- that's a very general question that -- and, again, the only way I could do that or answer that would be to assess that in each person that you're talking about.

I do know from the literature that motivation is almost always listed as one of the important criteria in successful cessation of smoking in cessation clinics.

Q But the folks that have tried many times and can't quit, or say they can't quit, are you saying it's the motivation and not an addiction? Is that what you're saying?

MR. STUHAN: Objection.

MR. BASSETT: Let me object to the form. The question was asked and answered I think at least twice so far.

MR. STUHAN: Object on the additional grounds that it's compound and argumentative.

Q (BY MR. ALLEN) You can answer.

A I believe if a person has -- who smokes on a regular basis has sufficient motivation and makes a sincere attempt to stop smoking, they would be able to do this.

In Ms. Acton's case, I'm certain she would be able to do this. Based on what I know of her history and her personalty, I believe she would have been able to do this. But she's never attempted.

Q She's never attempted to quit smoking?

A She's never attempted to quit smoking like I just described, with sufficient motivation and with sufficient reason on her part to stop smoking permanently and make a serious attempt at it.

Q Have you ever studied any of the

cases where they have people who smoke through a tracheostomy tube because their larynx has been removed because of cancer?

A I have seen patients do this when I was in a hospital setting.

Q And you think they lack sufficient motivation to stop smoking?

A Well, again, I don't know from that -- I mean, you're throwing a very general question at me that I really can't answer.

Q Sure.

A But if I talk to that individual, I'd probably get all kinds of answers.

I did talk with one patient years ago when I was a resident and going through an oncology service, and a patient was on a tracheostomy. And when I asked him about smoking -- continuing to smoke, he said, Well, I already have the cancer. Why stop now? So, obviously, he did not have the motivation to stop even though he had a serious illness that was considered to be

terminal.

Q Do you believe that nicotine is a psychoactive or mood-altering drug that can provide pleasurable effects?

A A -- if I could preempt my answer. A psychoactive drug is a drug that has an effect on the brain and neural activity. In other words, the activity or firing of the nerve cells in the brain.

Based on what I know from the literature and what patients report to me about smoking, they do describe the effects of smoking as pleasurable, as increasing their ability to concentrate and think on a particular task. And they also describe it as relaxing and calming to them.

So I would -- I would agree that it most likely has psychoactive effects. And there's many substances that are listed by psychoactive, including foods, chocolate, and other -- other things. Even some activities.

Q You mention in the Rule 26

information that there are numerous -- just like you just said -- repetitive behaviors, such as smoking, exercise, overeating, use of the Internet have been called addictions. Do you put all of those in the same category?

MR. BASSETT: Object to the form of the question.

Q. (BY MR. ALLEN) Go ahead.

A. Well, that was the point I was just making, that since a lot of these activities and things are considered psychoactive, based on what the patients -- the people who do these things report, a lot of -- there's been -- I saw listed in one article that I've read in the past where it was like a whole page of things and activities that have been described as addicting.

Internet was one of them, or computers, games, jogging, chocolate, soap operas. You name it. Almost to the point where the term has very little meaning.

It's almost lost its meaning; that many people would look on and feel and describe you with a lot of these behaviors, if you exhibited them, as being addicted to it, whether you're a twelve mile a day jogger or whatever. And that jogger would probably feel it was perfectly normal to him. That's what he wants to do. He enjoys it, and he does it.

Q So you put that same -- that activity in the same category as cigarette smoking as the -- I guess the motivation; is that correct?

MR. BASSETT: Let me object to the form. Vague and ambiguous.

A Yeah, I'm not sure I understand.

Q (BY MR. ALLEN) Well, do you put cigarette smoking in the same category as people who jog?

MR. BASSETT: Same objection.

A Well, like I said before, a lot of people smoke for different reasons. And they start for different reasons. They

maintain it for different reasons. And they quit for different reasons. And I would have to know a particular individual and why he did it one way or the other -- stopping, quitting, maintaining.

I don't put it anywhere. I'm just simply doing like you, I'm reading it as things that have been listed as being very similar and being addictive in terms of being addictive.

Q (BY MR. ALLEN) Have you ever seen a Surgeon General's report on any other behavior other than cigarette smoking and its addiction, like jogging, eating, using the Internet?

A Well, if you're talking about the '88 report, that was almost exclusively -- was smoking.

Q I'm talking about any Surgeon General's report.

A The only one I can remember, I think the '64 report when it was -- especially when it was talking about habits

and stuff, looked at -- I know it looked at -- I'm almost certain it looked at caffeine and coffee, for example. It was really talking about coffee, but it was caffeine.

Q Certainly not the Internet, I guess?

A No. It wasn't present in '64.

Q Let me just ask you this: Do you believe the '64 Surgeon General's report is more authoritative than the 1988 Surgeon General's report?

MR. STUHAN: I object to the question absent some more definition on what subject.

MR. ALLEN: I thought we agreed the stipulation is to object to the form. You want to object to the form, or you want to testify?

MR. STUHAN: Yes, I just have.

Q (BY MR. ALLEN) He objects to the form. You can answer the question.

A I'm not sure what you mean by

authoritative. But when I read these two reports, the 1964 report, I can identify with what this report is saying much better from what -- from my experience with smokers and what people report to me as to why they smoke and so forth, than with the '88 report.

Q So do you believe, then, that from a medical standpoint the 1966 (sic) report is more valid than the 1988 Surgeon General's report?

MR. BASSETT: Object to the form of the question.

A I'm not in a position to determine the validity of the two reports, and I wouldn't attempt to do that. I'm merely saying that if you look at the distinction in here between addiction and habituation and so forth, to me it makes more sense to classify tobacco smoking in the habituation category than the addiction category as it is defined in this report.

Q (BY MR. ALLEN) Do you believe

that nicotine has anything to do with making cigarettes habit forming, if you want to use that term?

A I -- again, I have read the literature like I have with the association of smoking with various medical diseases. And I have read articles and reports or whatever where various authors do believe that nicotine is the primary drug in cigarettes that has the psychoactive effects that the patients report when they smoke cigarettes.

And, of course, this would be consistent with the DSM-IV. They don't have tobacco dependence. They have nicotine dependence listed. And they most likely got this from that report and other sources.

Q So you believe that?

A But I've never studied nicotine and whether or not that's absolutely required for smoking behavior. And likewise, though, I have no reason to challenge that assertion.

Q Sure. Are you familiar with the Center for Disease Control studies in 1994 where they found that about seventy percent of the forty-six million then current smokers in the United States would like to quit smoking, but less than three percent are able to remain tobacco abstinent for one year?

A I've seen that statistic. I couldn't remember where it came from.

Q You're not going to try to challenge that statistic in this case, are you?

A I've seen the figures several times that there was at any one time probably about forty-five million people in the United States who are smoking, and I've seen other figures where half of all people who started smoking have stopped; that ninety-five percent of them stop without assistance; that -- and then there's a certain relapse rate. And I think this is the one that you quoted. So --

Q I'm just asking are you going to disagree with that statistic? Real simple.

MR. BASSETT: Object to the form.

A This -- I don't disagree with it from the standpoint of having any data or whatever to disagree with it.

Q (BY MR. ALLEN) That's all I was asking, Dr. Patterson.

Do you agree that the American Psychological Association considers nicotine in cigarettes to be addictive?

A Say it again. I'm sorry.

Q Do you agree or disagree that the American Psychological Association believes that nicotine in cigarettes is addictive?

A I've already stated that I don't believe cigarettes are addictive.

Q No. I'm asking you --

A The American Psychological Association are psychologists. They're not M.D.s. They're not psychopharmacologists. And I don't feel they're even qualified to be commenting on addiction or dependence of

various drugs.

Q The question I have is do you understand that they believe -- that organization as a whole believes that cigarettes are addictive or can cause dependence?

A I have never heard them say that. I've never read any document where the psychological association took that position.

Q What about the American Psychiatric Association?

MR. BASSETT: Object to the form of the question.

A What about -- I mean, have they said the same thing?

Q (BY MR. ALLEN) Yeah.

A Is that what you're asking me?

Q Yes.

A I don't know if they have or not.

Q If they did, you would disagree with it? Would that be a fair assessment?

A If the American Psychiatric

Association stated that smoking is addictive, I would be very surprised, because they don't use that term.

Q What about dependent?

A If they said it's dependent, which they do say in their manual, the DSM-IV -- they list the criteria, and they have nicotine listed as dependent.

But in the patients I've seen, the patients that I'm aware of and that I've talked with and so forth, these patients would not meet the criteria for dependence as their own book outlines.

Q Do you know -- can you name any major health organization that has made the statement, as you, that nicotine in cigarettes does not cause dependence?

MR. BASSETT: Object to the form of the question.

Q (BY MR. ALLEN) I'm just asking. Can you name one?

A Can I name an organization that nicotine does not cause dependence?

Q Yes, sir.

A No, I can't name a specific organization right off the top of my head.

Q Did the tobacco executives that testified before congress ask you about addiction before they went up there and testified before congress that they believe nicotine is not addictive?

A No.

Q Would you agree that the withdrawal period for nicotine -- the acute withdrawal period for nicotine averages about four weeks?

MR. STUHAN: Objection. Assumes facts not in evidence.

A Would I agree that the withdrawal period for nicotine lasts about four weeks?

Q (BY MR. ALLEN) Averages about four weeks.

A Averages four weeks. I've never seen a patient that I thought was in withdrawal from stopping smoking or withdrawing from nicotine, so I can't

comment on that.

Q Well, can you comment on when you would expect those symptoms, whatever symptoms they may be, would show up?

MR. BASSETT: Object to the form of the question.

A According to the DSM-IV, the symptoms have to show up within twenty-four hours or one day.

Q (BY MR. ALLEN) Well, if that's true -- well, let me ask you this: Do you know of any literature that indicates how long it takes before withdrawal symptoms show up from nicotine?

MR. BASSETT: Objection.

MR. STUHAN: Objection. Argumentative and assumes facts not in evidence. Assumes facts contrary to this witness's prior testimony.

Q (BY MR. ALLEN) You can answer.

A I don't know of any literature personally. But according to the way I understand the committees work, that this

information that they put in here is supposed to come from their review of the literature. And, therefore, I have to assume that they picked the twenty-four-hour period based on some literature that they reviewed.

If -- as a psychopharmacologist, knowing that the half life of nicotine is very short -- in other words, the drug doesn't stay in your system for a long time -- I certainly wouldn't have any argument with the fact that if you have a withdrawal syndrome from stopping nicotine -- I would certainly expect it to occur at least within a day because of the short time that the drug stays in your system. And that's a well-known phenomenon, that withdrawal symptoms tend to start showing up depending on how long the drug stays in your system; and, therefore, how long it takes to get it out of your system to produce the withdrawal.

Q Would you agree or disagree with

this statement, that the tobacco cigarette is the most toxic and addictive form of nicotine delivery that has ever been widely used?

MR. BASSETT: Object.

A Well, in -- I have never seen a patient -- and it's not listed as a characteristic of nicotine in the DSM-IV as being intoxicating.

Q (BY MR. ALLEN) Well, do you agree or disagree? I think it says toxic. I don't think it said intoxicated.

Let me read it again. "The tobacco cigarette is the most toxic and addictive form of nicotine delivery that has ever been widely use." The question is: Do you agree or disagree with that statement?

A Well, my interpretation of toxic would be intoxication. If that's not what they mean, I would have to know what they were talking about specifically.

Toxic in terms of killing you, like a nerve gas. Toxic in terms of making

you sick. I'm not sure what they're talking about.

(Plaintiff's Exhibit D was marked for identification.)

Q Dr. Patterson, are you familiar with the Practice Guidelines for the Treatment of Patients With Nicotine Dependence published by the American Psychiatric Association?

A The practice guidelines for nicotine -- no, I haven't read those.

Q Is that because you don't generally -- well, either don't recognize it as a condition, or is it because you don't treat those kind of patients?

MR. BASSETT: Object to the form of the question.

A I have read the practice guidelines from the APA's on -- APA on the disorders that I see more frequently, which is depression and anxiety disorders. And I've read those two guidelines. I have some schizophrenics and manics, so forth, and I

haven't read those.

And likewise, like I told you earlier, I don't see patients for tobacco dependence or nicotine dependence.

Q (BY MR. ALLEN) Sure. But of the practice guidelines that you use, do you find them to be standard and authoritative?

A Well, certainly in the area of depression and anxiety. I had no problem with those. I felt they were fairly consistent with my practice.

Q Do you use them in your practice I guess is what I should have asked?

A Yes.

Q Were you aware that the APA suggested this: That actions to change public policy towards tobacco are very important to decreasing the prevalence of smoking, and psychiatrists are strongly urged to support such actions?

MR. BASSETT: Object to the form. Oh, I'm sorry, you didn't --

MR. ALLEN: Let me read the whole

paragraph, then y'all can object.

MR. BASSETT: Will you let him see it?

MR. ALLEN: Sure. Sure. Let me read it first.

Q (BY MR. ALLEN) Do you recall that sentence, or do I need to start over?

A I recall it.

Q The APA's Position Statement on Nicotine Dependence lists the more important actions needed. And the first thing is encouraging appropriate diagnosis and treatment of nicotine as a co-morbid condition with other psychiatric disorders; b) increasing state and federal taxes on tobacco products and applying the proceeds of such taxes to the prevention, treatment, and research of nicotine dependence; and c) changing the warning labels on tobacco products to include the high likelihood of developing -- include the high likelihood of developing dependence on nicotine; and d) advocating for health insurance coverage of

treatment of nicotine dependence by qualified health professionals.

Were you aware that that was the APA's position?

A No, I never read that position before.

Q Now that you are -- have it in front of you, would it be fair to say today is the first time you've ever seen that?

A Yes.

Q Were you aware in the APA's guidelines that they indicate that secondhand smoke causes the death of thousands of non-smokers and morbidity in children and other relatives of smokers? Were you aware that the APA took that position?

A No.

Q And that they indicate that the severity of nicotine dependence can be illustrated by the fact that only thirty-three percent of self quitters remain abstinent for two days, and fewer than five

percent are ultimately successful on a given quit attempt? Were you aware of those statistics?

MR. STUHAN: I'm going to object to questions about statements coming out of documents where the witness doesn't have an opportunity to examine the document.

A You gave that figure a while ago from another document, so I don't have any reason to dispute it.

Q (BY MR. ALLEN) Did you know that the APA's position was that cessation of smoking can cause slowing on EEG, decreases in cortisol and -- I'll let you read it. How do you pronounce that?

A Catecholamine.

Q -- catecholamine levels, sleep EEG changes, and a decline in metabolic rate? Were you aware of that?

MR. BASSETT: I'm going to object to the form of the question.

A Were they aware that they stated this?

Q (BY MR. ALLEN) Yes, sir.

A I wasn't aware that they made this statement.

Q Were you aware that nicotine withdrawal caused those conditions?

A The only one that -- that I have some knowledge of would be the metabolic rate as it relates to gaining some weight after stopping smoking. We know this is something that is generally observed. And this has been written about before in some of the documents and papers that I've read.

But like the slowing of the EEG can occur, it occurs just when you're getting drowsy. So I don't know what to make of that.

Q Well, I mean, do you disagree with the APA's position that nicotine withdrawal causes that?

MR. BASSETT: Object to the form of the question.

Q (BY MR. ALLEN) EEG changes.

A I don't have any information,

data, or resources to dispute it or otherwise. But, obviously, I'd want to know what's the significance and so forth.

Slowing of an EEG, like I said, occurs just if you -- if we walked out of this room, you cut the light off and just threw your head back a little bit, your EEG would slow. I don't know what that would mean.

Q Would it be fair to say you've never studied the effects of nicotine and its EEG effects on patients?

A I have never studied that.

Q Have you ever studied the changes in those chemicals, that I can't pronounce, caused by --

A Is that the same?

Q Yes, sir.

A Catecholamines?

Q Yes, sir. Have you ever studied that --

MR. BASSETT: Let me object. I'll go ahead and put my objection --

MR. ALLEN: I'll give you that one. I'll give you that one.

Q (BY MR. ALLEN) Go ahead.

A I have never studied it. But being a pharmacologist and so forth, nicotine is actually an activating drug even though most people who smoke will tell you it calms them.

CNS-wise, it's activating, and in the periphery it's activating with some increase in catecholamines. So you would expect if you're smoking you have a certain level that it might go down. But, again, what's -- the significance would be nil to me. I wouldn't know. It's just -- it's corre-- I can't say the word.

Q Correlation?

A Correlative information. And it's like saying eighty percent of men over age 50 who die of a heart attack drink Cokes. Well, eighty percent of men may drink Cokes anyway. It's correlations.

Q Do you know what studies the APA

went through before they published that correlation?

A No. But my comment would be the same, that they don't comment on the clinical significance of it.

Q I see. Let me ask you this: You mentioned that you had some experience in pharmacology. And you prescribe drugs, don't you?

A Yes.

Q Do you know who publishes the PDR?

A Who publishes the PDR?

Q I'm sorry, let me back up. Do you know -- in the PDR you've got your drug information? You understand that each drug manufacturer under FDR rules when they get their drugs approved, they have to have the PDR sheet approved by the FDA as well?

A Uh-huh (affirmatively). It's called the insert.

Q Sure. And do you understand the FDA has to review that and approve it before it's released in the PDR?

A Yes.

Q Were you aware that the treatments for cigarette smoking, NicoDerm, have talk and refer to nicotine dependence and addiction?

MR. BASSETT: Object to the form of the question.

Q (BY MR. ALLEN) Were you aware of that?

A I've never read the PDR insert on nicotine gum or patches.

Q So you can't comment on it one way or the other?

A And I really -- really couldn't comment on that.

(Plaintiff's Exhibit No. 341, marked for identification.)

Q That's fine. Let me show you an exhibit that I've labeled as Plaintiff's Exhibit 341, which is a tobacco document produced to us. Have you ever seen that document before?

A I have not seen this specific

document. There's some sentences in here that I've read other places, but not -- not together like that.

MR. STUHAN: Excuse me, do you have extra copies of that?

MR. ALLEN: No.

MR. STUHAN: May I see that?

MR. ALLEN: Sure. Go ahead. By the way, Rick, for reference, I think these numbers correspond with the exhibits on our exhibit list.

MR. STUHAN: Are you referring to the yellow sticker on the document?

MR. ALLEN: Yeah. I think you'll find that that corresponds with our exhibit list. I believe.

MR. STUHAN: And the number attached to this one is what, now?

MR. ALLEN: 341.

Q (BY MR. ALLEN) Do you know what it means in this document dated July 17th, 1963 that nicotine is addictive?

MR. STUHAN: I object to that

question.

MR. ALLEN: I just asked if he knew what it meant.

MR. BASSETT: I understand. We can still make the objection, though.

MR. ALLEN: Sure. I assume you're just going to object to the form?

MR. BASSETT: Object to the form and to the general use of the document.

MR. STUHAN: The witness has testified he's never seen it before, so asking for his contemporaneous understanding of a document that he's never seen before strikes me as impermissible in and of itself.

Beyond that, the question is objectionable because it's asking him to speculate what the author of somebody -- some document meant when he wrote something thirty some years ago.

A I don't know who wrote this. I don't know what context it was written in. I have read the Battelle Hippo I and II

reports before and know something about them. The Griffith Filter I've never heard of.

And if this, for example, is an executive with a tobacco company or with -- I don't know who this is from. But if it's a non-medical person or a medical person, I would still question and take issue with nicotine being addictive.

Q (BY MR. ALLEN) So you don't know what they meant back in 1963 -- or what was the date again?

A You said 1963.

Q Well, don't trust my memory. See what the document says.

A Okay. July 17th, 1963.

Q Would that have been before the Surgeon General's report that you brought in here today that we've made Exhibit C?

A It would be before it was published, but not before it was written.

Q Right. Do you know what it means when it says, "We are, then, in the business

of selling nicotine, an addictive drug effective in the release of stress mechanisms"?

MR. BASSETT: Object to the form of the question.

Q (BY MR. ALLEN) "But cigarettes - we will assume the Surgeon General's Committee to say - despite the beneficent effect of nicotine, have certain unattractive side effects: 1) They cause, or predispose to, lung cancer; 2) They contribute to certain cardiovascular disorders; and 3) They may well be truly causative in emphysema."

Do you have any idea what they're referring to?

MR. BASSETT: Let me object to the -- you go ahead.

MR. STUHAN: I have the same objection to that question that I had to the last question. Same objections.

MR. ALLEN: Sure.

A Again, not knowing who wrote this

or what context or whatever -- I don't know anything about the business of selling nicotine. I don't sell nicotine. I would have nothing -- I'm not a marketing person, et cetera.

The addictiveness of the drug I've already addressed. The release of stress mechanisms, I'm not sure what they mean by that. If they're saying that it has a calming effect on people who smoke cigarettes, I would agree with that.

And then it says the Surgeon General has said it has unattractive side effects despite the beneficial effects. I do know some of the beneficial effects in nicotine. I mentioned increased concentration. It increases bowel -- not bowel movements, but the operation of the bowels, for example; and has several beneficial effects that I've read about before that was in some of the old literature. And it keeps weight down, et cetera.

The unattractive side effects, we've talked about this before. There is definitely -- as I understand the literature and as I was trained in my medical training -- that there is a statistical correlation between cigarette smoking and certain diseases, such as lung cancer, cardiovascular disease, and pulmonary disease, the three things that I've already talked about before.

Q (BY MR. ALLEN) Do you believe cigarette smoking causes lung cancer?

MR. BASSETT: Let me just object. It's asked and answered.

THE DEPONENT: I'm sorry, say it again.

MR. BASSETT: No, I was just interposing an objection to the question.

THE DEPONENT: Oh, okay.

A I accept the data that I've read that there is an association. I cannot say from -- from information that I've read. I'm not sure oncologists or pathologists or

anybody else can say definitively that they have proven that smoking causes this lung cancer. They've definitely proven the association statistically.

Q (BY MR. ALLEN) Well, in your own mind do you believe that smoking causes cancer?

MR. BASSETT: Same objection.

Q (BY MR. ALLEN) Lung cancer in particular.

A I think it's possible that smoking causes lung cancer. But I don't know that. I do know it's associated with it for sure.

(Plaintiff's Exhibit No. 331, marked for identification.)

Q Let me show you Plaintiff's Exhibit 331, which is -- and I'll tell you it's difficult to read. But it's labeled confidential and entitled A Tentative Hypothesis On Nicotine Addiction for The British-American Tobacco Company, Ltd. I'll ask you if you've ever seen that document before.

A Is this the Battelle report, Battelle report?

Q I'm not sure.

A B-A-T- --

Q Could you recognize it by just what you see there?

A Boy, you're right. It's tough to read, even with my glasses on. This looks like some of the papers that I reviewed probably a year or two ago that were commissioned, if you will -- some research that was commissioned on rats that was done as part of the -- maybe the Hippo I or the Hippo II or the, I think, what they were calling the Battelle report. But this looks like something that I've read before in one of those reports, basically summarizing what they had found with these rats.

Q Do you recall the portion of it where it says, "If nicotine intake, however, is prohibited to chronic smokers, the corticotropin-releasing ability of the hypothalamus is greatly reduced so that the

individuals are left with an unbalanced endocrine system. A body left in this unbalanced status craves for renewed drug intake in order to restore the physiological equilibrium. This unconscious desire explains the addiction of the individual to nicotine"?

Does that sound like they're talking about rats?

MR. BASSETT: Object to the form of the question.

A Well, if I -- I'm using my memory here. But the Tobacco Institute, or whoever it was that commissioned that research to be done, asked two experts, I believe it was, to review that data and to review their material and conclusions.

And as I recall, for one thing, all of this work was conducted on rats. They then took a giant leap and took the information that they found in rats and assumed this would occur in humans. It was a hypothesis.

And in the critique from the two experts, they use words like "junk science," "incorrect conclusions," et cetera, et cetera. And that's strictly somebody's hypothesis on what might keep people smoking or what effect might be if they stop smoking. But it was highly criticized as I recall.

Q (BY MR. ALLEN) It was commissioned by the tobacco companies, then criticized when the results came out what it did?

MR. BASSETT: Object to the form of the question.

Q (BY MR. ALLEN) Who highly criticized it I guess is the question?

A They commissioned two experts to review all the data in the conclusions to determine the validity of their work that had been done, as I recall. And these -- both of these so-called experts were very critical of all of this data.

Everything -- stuff that -- that I

wouldn't be an expert in. But even the type rats that they used, they even criticized. The type rats that they used in their studies.

Q And who are these experts you're talking about?

A Well, I don't remember their names. But they were two experts, apparently at the time, that worked in this field.

Q Who commissioned them?

A I think it was the same -- I think it was the Tobacco Institute, I believe, or the British, BAT.

Q Yeah, BAT. If the tobacco companies didn't think nicotine would cause dependence, why do you suppose they would have internal memorandum that says nicotine should be delivered at about 1 to 1.3 milligram per cigarette, the minimum for firm smokers; the rate of absorption of nicotine should be kept low by holding pH down, probably below 6?

MR. BASSETT: Let me object to the form of the question.

Q (BY MR. ALLEN) I mean, from your expert opinion, if it's not addictive, why do you suppose they would be trying to regulate the dose of nicotine?

MR. BASSETT: Well, that wasn't the question you asked. You asked the question about why the industry -- if they didn't -- the industry, then, thinks somebody was doing certain things. And I'm not sure that's ever been discussed or raised with Dr. Patterson.

Q (BY MR. ALLEN) Go ahead.

A I would assume since nicotine is considered a psychoactive substance, much like a lot of substances -- and I'm not sure it would be much different than eating a candy bar.

If you ate just a sliver of a piece of chocolate, it would give you a certain response. If you ate the whole candy bar, it would give you a certain

response. If you ate a whole bag of candy, you might get sick and throw up.

I think in terms of my interpretation would be is perhaps they have done some research or whatever -- I don't know. That's pure speculation -- as to what might be a level that smokers find an optimum dose, if you will.

And I wouldn't see this any different than what we try to do with a lot of other drugs, trying -- the biggest challenge we have in drug research is finding the dose that has the best effect.

Q. From a psychiatric or, I guess, psychological standpoint, why would they be interested in studying current youth jargon, together with review of currently used high school American History books and the like sources for valuing things, that it might be a good start in finding a good brand and name theme?

MR. BASSETT: Let me object to the form of the question.

MR. STUHAN: I object further to the question on the ground that it calls for speculation about someone else's mental processes; and for the additional reason that I think it's fundamentally unfair to be asking the witness about questions drawn out of documents without giving the witness an opportunity to examine the statement in the document in context.

Q (BY MR. ALLEN) You can answer.

A Would you repeat it? I'm sorry.

Q Why do you think the tobacco companies wanted to do a careful study of the current youth jargon, together with a review of currently used high school American History books and like sources for valuing things, that might be a good start at finding a good brand name and image theme?

MR. BASSETT: Same objection as stated before.

A That honestly makes no sense to me. I have no idea what they're saying.

Q (BY MR. ALLEN) And then they say it's obviously a task for marketing people, not research people.

A Obviously, it's for somebody other than a psychiatrist to understand.

Q So you don't think that's -- okay. This is another interesting document I want to ask you about. Have you been provided with any of the internal tobacco documents that indicates that they were studying the effects that ammonia and its salts had on smoke quality and its enhancement of the nicotine delivery?

A Not that I recall.

Q Nobody has ever shown you that?

A As I said earlier, I do remember Hippo I and II. I think I remember this document that you gave me. And then I remember the two critiques of the -- those three documents.

Q What do you think it means when they indicate that recent investigations indicate that natural or added ammonia and

its salts in tobacco and smoke play an important role in determining the acidity or alkalinity -- that's the pH -- of smoke. This in turn determines the amount of free and combined nicotine present in smoke which strongly influences the way in which the nicotine is perceived by the smoker?

MR. BASSETT: Let me object to the form of the question for the reasons that you're asking him to interpret a document that he's not seen and he's unfamiliar with that he's previously testified to.

MR. STUHAN: And I object for the further reason that it again calls for speculations about somebody else's thought processes. I object to you asking about a document without showing the witness the document. And I finally object to the question on the ground that it's compound.

A I'm obviously not an expert on nicotine content in cigarettes and smoke. I'm certainly not a -- I'm not a chemist.

I think I can understand some of

what it's saying in terms of they're talking about free nicotine. And I assume there's some nicotine in smoke that's bound in some way with some other molecule that may not have a psychoactive effect; and that they -- they could perhaps control the amount coming out or whatever.

As I understood -- as I've understood in the past as -- really as a layman really in that tobacco companies were required by using smoking machines to meet certain levels of nicotine in tar and have those published on the cigarette package. So I would assume they would make some effort to stay within that -- within that range.

And, again, it's -- it is speculation as to why that would be done, who did it, et cetera.

Q (BY MR. ALLEN) Does it sound like to you, though, that they can regulate the amount of nicotine based on use of ammonia and ammonia salts?

MR. BASSETT: Object to the form of the question for all the previous grounds stated.

A Yeah. What I said a while ago was it sounds like whoever wrote this stated that using ammonia or ammonia salts might have an effect on the amount of free nicotine that comes through the smoke.

But the motivation for doing that or whatever, I have no idea what that would be.

Q (BY MR. ALLEN) So you --

A I would have no way of knowing.

Q You couldn't say, then, that the purpose of optimizing the amount of nicotine is to keep people hooked?

MR. BASSETT: Object to the form of the question.

A No. I -- I gave you an example, for example, that I might think of as to why they might be interested in how much nicotine is delivered since it has to be -- had to be published. And especially if

you're getting into things like low tar, low nicotine, lye and so forth.

As I understand it, the FDC or whoever regulates that has requirements for being able to use that term.

Q (BY MR. ALLEN) But what I'm saying is you can't --

A So I can't say what --

MR. BASSETT: Let's not interrupt him.

Q (BY MR. ALLEN) In other words, you can't come into court and say that the purpose of that is as you suggest, as opposed to the motivation being to try to keep people hooked on their product?

MR. BASSETT: Object to the form of the question.

A Yeah, I can't say what the motivation of that was.

Q (BY MR. ALLEN) Did you -- and maybe -- I apologize for getting delayed. But do you believe that nicotine is the part of cigarettes that cause the drug to be

habit forming, as used in the Surgeon General's report in 196- -- whatever it was?

MR. BASSETT: Object to the form of the question.

A As I recall, the '64 report did not make the conclusion, like the '88 report, that nicotine was the primary substance that caused smoking to be a habit. I think it does talk about nicotine being in cigarettes and so forth and being delivered by cigarettes. But I don't remember it stating that.

Q (BY MR. ALLEN) Well, do you believe, based on whatever you've read, that the qualities of cigarettes that cause folks to become -- have the habit, I guess if you want to call it that, of smoking would be the nicotine delivery?

MR. BASSETT: Let me object to the form of the question.

Q (BY MR. ALLEN) If you know.

MR. BASSETT: If you understand the question.

A I know nicotine is produced by cigarettes based on the literature. I don't know specifically that it's been definitively proven that that is the only substance.

As I understand it, there's perhaps thousands of chemicals in cigarette smoke. And I don't know what's doing what. I do know there is some literature stating, like the '88 Surgeon General's report, that that is the primary drug that is involved in determining whether or not people continue to smoke. But I also know people who do smoke do stop smoking; and, therefore, it definitely is not one hundred percent.

And even in some of the rat studies that I looked at, for example, where they deliver nicotine by bar pressing, one-fifth or twenty percent of the rats won't self- deliver nicotine at all.

And then another group has a very low level of bar pressing. And this is consistent with what I was saying a while

ago. Everybody is different, and their response in -- to cigarettes and nicotine in it or whatever would be -- would be different. You would have to look at each one.

And I would not make just a blanket statement that nicotine is what causes people to smoke and keeps them smoking forever, because that's not consistent with the facts.

(Plaintiff's Exhibit No. 1250, marked for identification.)

Q (BY MR. ALLEN) Let me show you Exhibit No. 1250, which is an RJR document labeled as confidential, entitled Research Planning Memorandum On The Nature Of The Tobacco Business And The Crucial Role Of Nicotine Therein, and ask you if you've ever seen that before.

A I've never seen this. Do you want me to look at more of it?

Q Let me just ask you about certain parts of it. Read the highlighted portion

on the first page. And just read it into the record, and that way I won't have to look over your shoulder.

MR. STUHAN: Can I assume that the highlighting was your own and not in the document as it was produced?

MR. ALLEN: You can assume that.

A "Memorandum: In a sense, the tobacco industry may be thought of as being a specialized, high ritualized and stylized segment of the pharmaceutical industry. Tobacco products uniquely contain and deliver nicotine, a potent drug with a variety of physiological effects. Related alkaloids, and probably other compounds, with desired physiological effects are also present in tobacco and/or its smoke. Nicotine is known to be a habit-forming alkaloid, hence the confirmed user of tobacco products is primarily seeking the physiological satisfaction derived from nicotine and perhaps other active compounds. His choice of product and

pattern of usage are primarily determined by his individual nicotine dosage requirements and secondarily by a variety of other considerations, including flavor and irritancy of the product, social patterns and needs, physical and manipulative gratifications, convenience, cost, health consequences and the like. Thus a tobacco product is in essence a vehicle for delivery of nicotine, designed to deliver the nicotine in a generally acceptable and attractive form."

MR. STUHAN: You want to limit the witness to reading the highlighted portion of the paragraph?

MR. ALLEN: He can read it all.

Q (BY MR. ALLEN) You can read it all if you want to, but I was just going to try to shorten it up.

MR. STUHAN: You might as well read the last sentence in the paragraph.

A "Our industry is then based upon

design, manufacture and sell of attractive dosage forms of nicotine, and our Company's position in our industry is determined by our ability to produce dosage forms of nicotine which have more overall value, tangible or intangible, to the consumer than those of our competitors."

Q (BY MR. ALLEN) Assuming that to be an internal tobacco document, would you agree with me that at least whoever wrote that memo inside RJR believed that the nicotine in the cigarettes was key to keeping people hooked?

MR. STUHAN: I object to the question. It, again, calls for speculation about somebody's thought processes.

I also object to the assumption that this is an internal company document. There's been no foundation for this document, and we've objected to it on that grounds.

A Well, as I recall -- it was a pretty long paragraph, but this sentence --

this paragraph is stating the same thing I stated; that there's a lot of different compounds in tobacco smoke. Nicotine being one of them.

Some people believe that is one of the compounds that, quote, causes people to smoke.

I know that smoking does have pleasurable effects. I know that people do talk about the taste of cigarettes, the calming effects, the relief of anxiety, et cetera. They seem to be addressing these issues sort of tangentially to deliver a product that's acceptable to the consumer, the person who smokes it.

It also states, though, just as I did, that there's possibly other psychoactive compounds as well that they're not aware of that may be contained in the cigarette smoke. And that's why I said earlier that I can't definitively say, yes, that is the only thing that is important in smoking, is the nicotine.

Q (BY MR. ALLEN) Well, just from this author's opinion, do you believe, based on what he is saying, that nicotine is important for the purpose of keeping the -- for making it habit forming?

MR. BASSETT: Same objections as stated before.

A I don't think he referred to -- stated habit forming. But --

Q (BY MR. ALLEN) Well, here. I'll let you see it.

A -- he does seem to be saying --

Q Where it says, Nicotine is known to be habit forming -- a habit-forming alkaloid, hence the confirmed user of tobacco products is primarily seeking the physiological satisfaction derived from nicotine.

A Yeah, I read that. But that's different than what you said. He says it's a habit-forming alkaloid. You said this -- habit forming, smoking being habit forming.

Q But you don't interpret that to

mean that they believe nicotine is what is the habit forming part of cigarettes?

MR. BASSETT: Object to the form of the question.

MR. STUHAN: I repeat my objections.

A Well, it does seem that they're saying that nicotine is one of the compounds that is important in people smoking cigarettes.

Q (BY MR. ALLEN) Do you disagree with that?

A Because of the nicotine that is delivered.

Q Do you disagree with that?

A I don't have any basis for disagreeing with it.

Q Let me go through and mark all the stuff you brought with you today, if you don't mind. You don't mind if I look at this, do you?

A Oh, no.

MR. BASSETT: Why don't we go

ahead and put on the record, too, I think we've already reached an agreement that those original documents from Dr. Patterson's files that you marked, you'll allow him to retain the originals and make copies to attach to the deposition transcript.

MR. ALLEN: Sure. And my originals will come back to me.

(Plaintiff's Exhibit E was marked for identification.)

Q (BY MR. ALLEN) I'm going to label this Plaintiff's Exhibit E, the deposition transcript of Ms. Acton. Are all of the notes that I see on the transcript --

A They're only on the front page, and they're mine.

Q That was --

A And that's the only notes I made.

Q That's the question I was going to ask you.

A Yes, sir.

Q Are all of the notes and markings,

I'll say, in the deposition your markings?

A Yes. Those were highlighted to catch my eye. Sort of like the highlighting you did on the last document.

Q Yes, sir. For example, at the top of the page it will have 6/29 to 6/30/98, six hours. Would that be the time it took you to read the deposition?

A Yes.

Q And you're keeping your time for billing purposes?

A Yes. And then I turn that in to my secretary, and she lists it on a time sheet that she keeps and then bills after the case -- usually after the case is closed, unless it starts going into a couple of years. And then I might split the bill. That's why I haven't billed on this case, since it hasn't been a year yet.

Q And then on 2/24/99 it shows Scan, one hour. Is that when you were preparing for the deposition?

A That simply means that there's a

time in between of which I need to refresh my memory as to certain events. When he was diagnosed; you know, some things that she said.

I concentrated on her deposition a lot trying to get a -- because I was asked to -- to form opinions about her personality, smoking behavior, et cetera.

(Plaintiff's Exhibit F was marked for identification.)

Q As far as the notes are concerned, would the same be true with Mr. Acton's deposition, which I'm labeling as Plaintiff's Exhibit F, all your notes --

A Yes.

Q -- markings? Are there any -- do any parts of Mr. Acton's testimony that you recall that are particularly important to any of the opinions you're going to offer today?

MR. BASSETT: Object to the form.

Q (BY MR. ALLEN) I mean, does anything stand out in your mind as really

driving home the point?

A I'm not sure I understand your question. I'm sorry.

Q Well, I know you said you read Mr. Acton's deposition. We really haven't talked a lot about that. And what I'm trying to ask is do you remember anything in going through his deposition that stood out in your mind that definitely confirms your opinions about Ms. Acton or any of the opinions your offering in this case?

A The biggest thing I remember about his deposition was it was relatively consistent with -- with the description of her smoking behavior with her own, in that she would put out a cigarette or he would ask her not to smoke in the car, and she usually wouldn't, et cetera. And that's the biggest thing that I remember. And that's a lot of what the deposition concentrated on.

Q How is that important to any of the opinions you're going to offer?

A How is that important?

Q Yeah. How is that important? You emphasize that, so I want to know.

A Two reasons is I'd like to know something about her credibility in what she's saying. She strikes me as an individual who's going to tell it just like it is, and she's going to be very blunt about it.

And the fact that she, in a sense, was being -- was having a great guilt trip laid on her, that her smoking in front of him caused his lung cancer. As I was reading the deposition and the comments she made, this was a real guilt trip on her. And you might anticipate that some people would do some skirting around questions and so forth, and she doesn't seem to do that. And he seems to verify her credibility in what she was saying in that regard.

So it helps me to understand and know more about does she seem to be telling the truth about whether she -- you know, you might read in her deposition, for example,

that she says she stopped smoking for six months. If she said she stopped smoking for six months, I would probably believe her. And when she said three -- three weeks or so, I believed her.

Q What about Mr. Acton? Did you find the same credibility in his deposition from your analysis?

A When it came to what I was just talking about, I do. When there was some questions asked about why he was filing the lawsuit -- and there was questions that I wasn't particularly interested in, but I read and remember. Does he have a will, and he wasn't sure who the beneficiary was and everything. I -- I had some questions about him. I would question his credibility, for example.

If I have a will, I think I'd know who my beneficiaries are, especially if I had made it recently.

Q Anything other than the issue of the will that you recall that would affect

the credibility of Mr. Acton in your mind?

MR. BASSETT: Object to the form.

A That one sticks out in my mind. He did seem to have some -- I can't recall specific ones. He did seem to have some memory lapses, and I marked some of these, that I thought he should be able to remember.

When you read his wife's deposition, you don't see those memory lapses. She --

Q (BY MR. ALLEN) Anything else? I'm sorry.

A I'm sorry. That's about it.

(Plaintiff's Exhibit G was marked for identification.)

Q I'm going to -- apparently, there's two parts to the deposition of Mr. Acton, and I'm going to label the second part as G, just for the record.

A I think his was done on different days or something.

Q Well, there may be several. What

is this? Is that another deposition?

A Yes. This is -- these were done at different times.

(Plaintiff's Exhibit H and I were marked for identification.)

Q Well, let me just go ahead and label them all. Label one of them as Exhibit H and the other is Exhibit I.

Did you do any marking or highlighting on the exhibits I have labeled as Plaintiff's Exhibit H and I?

A No. I knew that a more recent deposition had been taken on him that would cover almost everything that was covered in the original deposition, and so I reserved the marking parts. And many times the deposing attorney refers back to his original statements.

Q Did you read the depositions H and I?

A Yes.

Q But you made no notes? And I see no time notations on these depositions as

you did on the other.

A No.

Q Why didn't you make a note of the time on it?

A It -- you know, I'm not perfect. I just didn't -- I didn't do it.

Q You didn't. Are you going to charge for that time?

A Yes.

Q And then you have the medical records of Ms. Acton. Is that all the medical records you reviewed?

A That's all I could find. There was two boxes.

(Plaintiff's Exhibit J was marked for identification.)

Q I'm going to label that as Plaintiff's Exhibit J.

A That's the envelope that something came in, and I put it in there just sort of so I could hold them in my arms.

Q Is there anything in these?

A That's just my writing pad. I

just have a habit of taking that.

Q Do you have any notes in it?

A No.

Q Have we covered all the documents and information that you have reviewed to form the opinions you're going to offer in this case?

A Yes. Yes, we have.

MR. ALLEN: Do y'all have that summary of expected testimony?

Q (BY MR. ALLEN) Have we pretty well covered your testimony about the smoking behavior of Ms. Acton?

A Yes.

Q Have we covered the part of the Rule 26 information where it says you are expected to testify that the term "addiction" or "addictive behavior" had been defined in various ways over the years and that a variety of pleasurable, repetitive behaviors, such as smoking, exercise, overeating, and use of the Internet have been called addictions? Have

we covered that pretty well?

A I think we did.

Q Is there anything else you can think of you want to talk about or say about that other than what we've already said?

A No.

Q And there's another sentence that says you will also testify that there is nothing about cigarette smoking that impairs a person's ability to stop smoking. Is that your opinion?

A Yes.

Q "Dr. Patterson is expected to testify that cigarette smoking is a complex behavior and that to quit any long-term, repetitive, and pleasurable behavior such as cigarette smoking, a person must have motivation and make a serious attempt to quit."

Have we pretty well covered that aspect of your expected testimony?

A I think so. And my -- for example, when you were talking about

nicotine earlier -- and some of my experience with my own patients.

In an inpatient service, for example, we -- we at one time went through a phase when smoking was not allowed on the unit itself. They had to go outside. We went through a phase of ordering nicotine patches on everybody. Some of these patients would have them all over their chest, yet they would still go outside and smoke.

Now, they're getting the nicotine. But what you would see them doing would be out there smoking. Or they would be playing cards or whatever the case may be.

And that's the point I was trying to make, that we know they were getting nicotine delivered to their system. And if nicotine is the only motivation for their smoking, obviously they wouldn't have a need to smoke.

And that was -- that's why I was talking about the state-dependent nature of

smoking and it being a complex behavior, because we were giving them the nicotine. They smoked anyway. And that's the only other example that I might could think of that would try to illustrate my point.

Q Based on that analysis you just gave me, does that lead you to the conclusion that nicotine is not a motivational factor in people smoking?

A Like I've said before, I think based on what -- what I've read, that nicotine does seem to be one of the drugs that are in -- that is involved in having a psychoactive effect of calming people, making them feel less anxious or calmed down or whatever when smoking. But it doesn't seem to be the only answer.

Just like that report that you showed me where they were talking about there may be other things involved. And that, for example, might explain why they still smoke. They're getting other compounds. But I don't know that.

I still know, though, that from a psychiatrist's point of view, the socialization, the talking and being around the other patients, seem to be very important and associated with smoking itself. Much like happy hour and whatever.

Q Well, would those activities that you talk about, the pleasurable activities, impair a person's ability to stop smoking from a psychological standpoint?

A Well, obviously, if a person likes doing something, whether it's eating, jogging, or whatever it may be, playing golf, boating, they're most likely going to want to do it.

And if you block that behavior, they're most likely not -- they're going to not be too happy about it, and they're going to try to do it anyway.

Q What about the people that say they would quit smoking if they could? I mean, how do those folks factor into your equation?

MR. BASSETT: Object to the form of the question.

A Well, one of the points I've tried to make all along is I have a lot of patients who are going to try to take their drugs like I prescribe, who are going to try to lose weight, who are going to try to start exercising, and et cetera. And there's a difference between saying you're going to do something or you would like to do something and then actually making -- and this is what I was trying to emphasize earlier -- a serious attempt to do that. And I would have certain definitions of that with that particular patient. What constitutes a serious attempt based on some sincere motivation to stop, whatever that motivation may be?

Q (BY MR. ALLEN) Do you believe that people that respond to the surveys that say that they would quit smoking if they could really don't want to quit smoking? Is that what you're saying?

MR. BASSETT: Let me object to the form of the question. It's asked and answered. I think it's vague too.

A I do know that there have been surveys and they talk about, I think, upwards of two-thirds or so of people who smoke say they would like to quit if they could or something to that effect. You would probably get the same response with people who are overweight, et cetera.

But, for example, with Ms. Acton, I think if Ms. Acton decided she wanted to stop smoking and she made a serious attempt, I think she could do it. And there's a difference between just saying, yeah, I'd like to do that or I should do that and then really putting your mind to it, your effort, your will into actually making an attempt.

Q (BY MR. ALLEN) I may have asked this earlier today, but are there other depositions you have read other than the Actons?

A As I told you earlier, there was,

like, a three-part deposition each from Dr. Feingold and Dr. Thrasher. And in scanning over them, there was so little mention of her smoking behavior in it, that I just scanned them. Because most of it was what kind of cancer and what the x-rays showed, and it just didn't seem to be pertinent to what I was going to be forming opinions about.

Q So you aren't planning on commenting about their testimony?

MR. BASSETT: Object to the form of the question.

A Since they seem to deal mostly with his cancer, which, of course, is not my field, I -- I wouldn't expect to be asking any -- answering any questions about that, unless I'm specifically asked and it's a question that I feel I can answer.

Q (BY MR. ALLEN) You haven't to this date been asked to review any parts of their testimony to comment on?

A You mean by you?

Q No, by anybody. I mean by the tobacco lawyers. I mean, are there any specific parts of the depositions you've been asked to look at and comment on of Dr. Thrasher, Dr. Feingold, or anybody other than Mr. and Ms. Acton?

A Oh, no.

Q And have we covered all of the items you have reviewed that act as a basis for the opinions you offer here today?

A Yes. Except for, you know, numerous items, like readings and things that I've done as just a part of being a physician or psychopharmacologist and so forth. And I'd have no way of listing them, producing them, or whatever because it would be impossible.

Q What publications do you consider to be authoritative and trustworthy in the area of addiction?

MR. BASSETT: Object to the form of the question.

A There's a journal called

Psychopharmacology that I feel is important in the area of psychopharmacology as it relates to addiction.

I generally don't read addiction journals, per se, because they deal in different issues and many times are written by non-psychiatrists. So I tend to read journals that are either by psychopharmacologists and/or psychiatrists.

Q (BY MR. ALLEN) Do you recognize the specialty of any groups that study and research addictions?

A Well, there is a -- I believe it's called the American Board of Addiction Medicine or something like this. And I'm not sure whether it leads to certification or added qualifications. There's a difference, in that you might have added qualifications by completing their exam or whatever, whereas certification would be like my certification in psychiatry and neurology.

And I do know there is a group

that either certifies or grants added qualifications to physicians in what they call addiction medicine.

Q Do you belong to any of those organizations?

A No.

Q Have you ever?

A No.

Q And I think you just said you don't subscribe to any of their publications?

A No.

Q I've seen the term "some people crave cigarettes." Do you recognize that as a possibility?

A Well, obviously, anything is possible. I've heard people talking about craving everything from a steak to chocolate to cigarettes to a Margarita to whatever. And I'm sure -- I can't recall a specific patient. I'm sure I've heard patients say that before. But I've heard them say that in regards to a lot of other activities and

things as well.

Q How do you define craving?

A Craving I would -- I would define as an internal stimulus, psychological stimulus, to either obtain, experience, engage in, or whatever, a particular substance or activity. Again, whether it's craving playing golf or craving a steak or craving a good cup of coffee.

Q Would that include a craving for cigarettes?

A And craving -- I'm sure there are some people that might use that term with cigarettes as well.

MR. ALLEN: I have no further questions.

MR. STUHAN: I have no questions.

MR. BASSETT: I have no questions.

(FURTHER DEPONENT SAITH NOT)

C E R T I F I C A T E

STATE OF ALABAMA)

JEFFERSON COUNTY)

I hereby certify that the above and foregoing deposition was taken down by me in stenotype, and the questions and answers thereto were transcribed by means of computer-aided transcription; and that the foregoing represents a true and correct transcript of the testimony given by said deponent upon said hearing.

I further certify that I am neither of kin nor of counsel to the parties to said cause, nor am I in any way interested in the results thereof.

This the 14th day of March, 1999.

Sherry Tudor

SHERRY TUDOR,
Court Reporter and
Notary Public for the
State of Alabama at
Large